3500 l State of Maryland / Department of Health and Mental Hygiene [] [1 - Stata Ragistra Certificate of Death Rag. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Ž004 10:25 P Mary Elizabeth Von F. Morrill **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis 3201 River Crescent Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | March 9, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year)912 New York Months **Funeral** 1 ☐ M 2 🔀 F 92 Yrs 131-03-7889 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, Ita Medical Examinational be notified all once. 1 Tyes 2000 Annapolis Anne Arundel Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21401 3201 River Crescent Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 2 No
If Yes, Give
Year or Dates: 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes > XXNo Specify: Baltimore, Maryland 21215-0036 3 Widowed WDivorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Perkins Herbert Von Frankenberg 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 103 Kygers Hill Road Lexington, VA 24450 Beth Belmont/granddaughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 10/23/2004 Valhalla, New York Kensico Cemetery 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Annapolis, MD 21401 147 Duke of Gloucester St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 years Immediate Cause (Final HEAR CONGESTIVE Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Certification: To Be Completed by Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ned by the atten a detached for u in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ypertenon should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 perform 1 ☐ Yes 2 ☐ No 1∐ Yes 2 X No 26. Place of Death (Check only one) Physician: funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 🗌 Yes After this 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D3070 Zolen, 2000 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) PKWY, ANNAPOLIS, MD 2002 MEDICAL SCOTT 32. Aggistrar's Signature 31. Date filed (Month, Day, Year) State 1 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2 1 1 35002

		1 - State Registrar		Cei	tificate of	Death	Reg	. No.	00002
		1. Decedent's Name (First, Middle, La	st)	.4			2. Date of Death Month	Day Year	3. Time of Death
Physic Med!		Thomas	2.	Murphy	SR.		OCT. 25		3:34A M
Exami		4a. Facility Name (If not institution, giv	e street and number)			r Location of Death		4c. County of Dea	
		SOUTHERN MARYI	AND HOSP	ITAL	CLIN'	TON		PRINCE	GEORGES
Funeral		Social Security Number 6. S	-	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bi	rthplace (State or Foreign
Director		218-24-3143	IXM 2□F	75 Yrs.			MAY 14,		ARYLAND
pu 🖈		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	astion				10d. Inside City Limits
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within 72 hours after death with the Maryland liene. r then "natural", or Items 23s or 28e-f show the Medical Examiner must be notified at	Dire	ARYLAND PRINCI			10f. Zip Code		100	j. Citizen of What C	ountry?
ath v	Ta .	7203 MILLIGAN	· · · · · · · · · · · · · · · · · · ·			735		USA	
ar de tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	iver in U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
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od within 72 hours aff giene. er than "natural", or the Medical Exami	Completed	15. Decedent's E (Specify only highest gr	ducation ade <i>completed)</i>	(Give	ient's Usual Occup kind of work done o DO NOT use retired	durina most of worl	king	b. Kind of Business	s/industry
within ene. than "	ш	Elementary/Secondary (0-12)	College (1-4or 5-	+)		2)			
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ould Men narke	2	BENJAMIN WINF					MAGDALEN		
2 short and last mereum		19a. Informant's Name/Relationship (ral Route Number, C		
		THOMAS L. MURPE	IY,JRSO	N 256			H DR., WA		
000		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren	natory or other plac		Date 20	c. Location - City or	r Iown, State
Pag ment ent: ury		'4 ☐Donation 5 ☐Other (Special	y) TR	INITY ME	MORIAL	GDNS. 10	0-29-04	WALDOR	F,MD
permit. Pag Department Importent: I any injury o	1	21. Signature of Funeral Service Lice	M004	79/7 22	. Name and Addre		GBDUTG		
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Physician		Immediate Cause (Final disease or condition	ATho	oscleriti	Carl		Can Di	Cer	Onset and Death
/Medical		resulting in death)	и	a consequence of):	and.	e vancus	an or	sie e	_70_
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eath certificate be executed attending physician and for use as the burial-transit	/Medical								
eath cerl attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		T			23d. Date of de	livery
death le atter	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth : 4 ☐ Pregnant at		Ectopic pregnancy Other (specify)	'		Month	Day Year
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The law requires that the take has been signed by the page 2 should be detached.	by Pl	Part II. Other significant conditions	contributing to death bu	it not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
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T S Too	2	29b. Signature and title of certifier			29c. Licens			. Date signed (Moni	
		m Sida				45365		10-65	-5004
		30. Name and address of person who							
4	2	Sidarous, Michael G	. MD. 11701,	LivingstonR	cad Suite	101 Fort	Nashinator	1. MD.2074	-14
4	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature			2	1	,

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 1 - State Registrar 35003 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 23, Myrtle Irene Miller 2004 9:00 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Avalon Manor Nursing Home Hagerstown 5. Social Security Number If Under 1 Year I tf Under 24 Hrs. 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country)
 PA Funeral 8. Date of Birth (Month, Day, Year) Days Hours Min. 1□M 2√2F 174-20-6560 Director 79 16,1925 July Usuat Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Modical Examinational be notified at Director 1 TYPes 2 □ No MD Washington Hancock permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental hygiene. Important: if item 27 is marked other than "never any injury or other treuments." the 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 503 Quaker Creek Completed by Funeral 21750 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 NWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Recreational Facility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virgil Lynch Florence McKee ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie Rupenthal/Daughter 12611 Roby Ross Lane Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Pleasant Ridge Cem. 10/26/04 Needmore, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death HYPERTENSIVE Immediate Cause (Finat **Physician** CARDIOVASCULAR DISTRASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner DIVISION OF VITAL RECORDS, P.O. Box 68760, in the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. ohysician and the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetet death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 ☐ Yes 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation Injury within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 052323 Zie 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Khalid M.Waseem, M.D. 1126 Opal Court Hagerstown, MD 21740 31. Date fited (Month, Day, Year) NUV. 0 4 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 20 1 4 35004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Juley Frank Nazelrod 28 Oct 2004 4:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 109 West Street LaVale Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10**X**M 2□ F Yrs. Director 219-14-7465 July 4,1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits i Hygiene. other than "natural", or Items 23s or 28e-f ehow vent, It e Medical Examinat must be notified at 1 ☑ Yes 2 ☐ No Maryland Allegany LaVale Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 West Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Spinning Dept Fiber/Textile 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be find Mental I Walter Reed Nazelrod Myrtle Sue Alt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 Is
any injury or other treu Audrey V. Nazelrod-Wife 109 West St., LaVale, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Frostburg Mem. Park 1, 2004 Frostburg, Maryland 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease or complications that cause in e death. Do not enter the mode of dying, such as carriac in respiratory arrest the mode of dying, such as carriac in respiratory arrest the mode of dying. MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metatali **Physician** 91 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2-No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification; To Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🖫 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) ctor: After this y the funeral o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Oct. 29. 2004 D0017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34 NJ Bullino MO 922 L2 1/2/2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death Reg. No.

35005

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Physician /Medical **Examiner** physician and s the burial-transit The law requires that the death certificate be executed Box 68760 attending p P.O. the Records, of Vital To the Hospitel or Attending Physicien: After Division death. Director after within 24 hours a To the Funerel C

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Meda Catherine Oswald 23,2004 10:55 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeders Memorial Home Washington Boonsboro If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖸 F 89 Director Maryland 214-28-5332 June 6, 1915 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits of Health and Mental Hygiene.
Item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumstic event. The Medical Expression must be inclined at 1 ☐ Yes 2 No Completed by Funeral Director Washington Smithsburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11409 Wolfsville Rd. 21783 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specity only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bessie Hanna Draper Chester Calvin Kuhn Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane L. Kline (Daughter) 14110 Loy Wolfe Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 7 Oct.27,04 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State **=** ŏ Department of Importent: If any injury or once. Smithsburg Cemetery Smithsburg, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Mojuju J.L. Davis Funeral Home Smithsburg, Md. 21783)avis 23a Past. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anterio Schendie Cendiovana Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical *IF FEMALE* 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Mallins 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No AKINMINING 24a. Was an autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -tent mo D 18019 OCTOSER 23, 2004 1-40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vasant Datta 340 Mill Street Hagerstown, MD 21740 / 301-739-7100 31. Date filed (Month, Day, Year) State OCT 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 For State Registrer 35006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Vear O'Connell а м Roche /Medical October 19 2004 8:45 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1121 University Blvd. West, #716 Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 14, 1915 Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. Months 214-30-1071 1 □ M 2 🛱 F 89 Director Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits iner has be notified at Directo 1 ☐ Yes 2 X No Montgomery Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e 1121 University Blvd. West, #716 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. fited within 72 hours after 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White the Medical Exam 1 ☐ Yes 2 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home injury or other traumatic event, permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 is marked other any injury og other traumafter energen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Patrick Roche Margaret Kelly 19a, Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #716 t, Silver Spring, MD 20902 Joseph D. O'Connell/ Husband 1121 University Blvd. West, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln 20a. Method of Disposition 20c. Location - City or Town, State October 21, 1 XBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 2004 Cemetery Brentwood, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Gastric Cancer Month. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and -tran Due to (or as a consequence of): physicien a s the burial-i Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐ Yes 2 ☐ No Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 autopsy performed? certificate 2 😡 No Division of Vital 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2X No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the ft. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33224 October 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ram Trehan, M.D. 50 W. Edmonston Drive, #303, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **21** 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per Verb., G839, 01/05/2005dhb

State of Maryland, Department of Health and Mental Hygier 1 - State of Maryland, Department of Health and Mental Hygier 1 - State of Maryland, Department of Health and Mental Hygier 1 - State of Maryland, Department of Health and Mental Hygier 1 - State of Maryland, Department of Health and Mental Hygier 1 - State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department of Health and Mental Hygier 2 - O I State of Maryland, Department 35007 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 19, 2004 4:00 a M TERRY L. PALM/Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6620 Foxmeade Court Frederick \$212\subsection 62\frac{1}{2675} 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□**X**M 2□ F Yrs. 51 Maryland Director Usual Residence of Decedent 10a. State MD 10d. Inside City Limits 10b. County Frederick 10c. City, Town or Location Frederick 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6620 Foxmeade Court 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owned Insurance Agency Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles William Palm, Sr. Addie Virginia Goines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennifer Palm (Wife) 6620 Foxmeade Court Frederick, Md. 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 10/21/04 Smithsburg, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market Street Frederick, Md. 21701 23a. Part1. Soter the disease, or complication that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) FAILURE SPIRATORY UNKNOWN /Medical Due to (or as a consequence of) Examiner ATERAL SCLENUSIS (AMYOTROPHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1X Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 A Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed Box o Records, of Vital Division Attending ō To the Hospital

Funeral

in than "natural", or items 23s or 28s-f show the Medical Examinational be notified at

with the Maryland

death v

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If Item 27 Is marked other than 1ry or other traumatic event, the Ma

permit. Page Department of Important: If any injury or once.

Physician

attending physician and for use as the burial-transit

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signed l

s certificate has t lirector, page 2 s

After this certification funeral director.

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 2004

29b. Signature and title of certifier

JANIS

32. Registrar's Signature

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M, TAUB

N. Wolfe Street Baltimore, HD 2/287

29c. License number

RES-OOD

29d. Date signed (Month, Day, Year)

600

			State of Maryland / Departm		lental Hygien	ים חוול"	35008
			Registrer 1. Decedent's Name (First, Middle, Last)	cate of Death	Reg. N	2004	3. Time of Death
	Physicia /Medic		James Eugene peck Sr		October	32, 3004	0707 4 M
•	Examin			City, Town, or Location of Death		c. County of Deeth	
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7			Usual Residence of Decedent		Dept. 17	1771 1 011	
relian	show	Ĕ	10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits 1 Y Yes 2 □ No
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5	permir. Fages I and z should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.		1 🕅 Burial 2 □ Cremation 3 □ Removal from State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State	Cemetery 10/25	5/04 Ha	gerstown.	, Maryland
	permit. Pag Department Important: I any Injury o once.			me and Address of Facility Mi			, maryrand
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210	or Attending Physician: Iter death. Director: After this certifics in by the funeral director,	catl	2 Accident investigation 3 Suicide 6 Could not be 380 Place of Injury. At home, farm, street, if		28f. Location (Street	and Alumbas as Co	en l Pouto Alumbos
DIVISION	after of Direction by	ertificatio	4 Homicide determined 28e. Place of Injury - At home, farm, street, for building, etc. (Specify)	actory, office	City or Town, Sta		rar Houle Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C		urred at the time, date and place,	and due to the cause	(s) and manner as	stated. to the cause(s)
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	F3F8		> 11th	D46081	2	toher	77 2004
	11-1041		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	100	ا عود ا	74,2007
	24		Frank J Collins MD 11504 Pro	sfessional cour	+ Hage	rstown m	D 21740
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Frank J Collins MD 1150 & Proceedings of the filed (Month, Day, Year) 32. Registrar's Signature DCT 2 5 2004	W			

State of Maryland / Department of Health and Mental Hygiene 2004 35009 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ${\bf P}^{\,\mathsf{M}}$ OCTOBER 19, 2004 1:00 ROSSER LEE PARKER /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CORSICA HILLS NURSING FACILITY QUEEN ANNE'S CENTREVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**☆**M 2□F 75 Yrs. MAR. 27, 1929 VIRGÍNIA Director 140-20-9550 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ahow Pages 1 and 2 should be filed within 72 hours after death with the Maryla men of Health and Mental Hygiene.
set: If item 22 is marked other than "naturel", or Items 23e or 28e-f show ury or other traumatic avent, its Madicial Estonies of the modified at 1 ☐ Yes 2 🙀 No Director MD QUEEN ANNE'S **STEVENSVILLE** 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number **USA** 102 VIRGINIA ROAD 21666 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No 1946— If Yes, Give Year or Dates: UNK 1 ☐ Never Married 2 😿 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE à 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4 QUALITY CONTROL DIRECTOR U.S. POSTAL SERVICE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WALTER PARKER IDA JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 102 VIRGINIA ROAD, STEVENSVILLE, MD DOLORES PARKER/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury of once. * 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATORY 10/21/2004 STEVENSVILLE, MD 21. Signature of Furier / Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Concer **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year ŏ in the past 12 months? Month Day 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 robably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s 2 No 1 ☐ Yes 1 ☐ Yes 2€No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of De th 28b. Time of Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Vithin 24 hours are To the Funeral Dir Hospitel 1 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 101 29b. Signat we an Little of a rtifler 137136 UW completed cause of death (Item 23a) (Type, Print) Drue Clarke, MD 21619 10/21/04 D. Donate 108 20 31. Date filed (Mo State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 35010 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Physician Ronnie Perkins 10 16 04 6:45A.M. /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince Georges Laurel Cherry Lane Nursing Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 02 17 7. Age (In yrs. lest birthday) **Funeral** Birthplace (State or Foreign Country) Days Months Hours 1 ☑ M 2 🗆 F Yrs. 577-84-6781 Director Washington, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene "important: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner mast be notified as 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD 11℃ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7501 Slate Drive 21244 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify: <u>≨</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)
3 yrs. Elementary/Secondary (0-12) Clerk U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAmes A. Perkins Joanna R. Purdie 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) <u> Joyce Perkins/Sister</u> 7501 Slate Drive, Baltimore, Md. 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Harmony Memorial Park 10-25-04 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 mai 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examin law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): signed by the a ld be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy s certificate has b diractor, page 2 s 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: rector: After this certification by the funeral director, 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: P 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of De 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Certification: Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation death. 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) in amount stated. within 24 hou To the Fune completely fi 29a. Certifier edical To the 29b. Signature end title of certific 29c. License number 29d. Date signed, (Month, Day, Year) 30. Name end eddress of person who complete d cause of deeth (Item 23e) (Type, Print) 6201 Greenhe OKWA RA IKechi red 31. Date filed (Month, Day, Year) State OCT 2 1 2004

ORIGINAL

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** FRANCES MARY PARSONS OCT 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 5, 1933 **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 □ Months Days Hours 020-30-5614 71 Director Ireland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural" ~ "" any injuryor other traumatic avent." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's College Park 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5014 Pierce Avenue 20740 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify. þ White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1-4 Elementary/Secondary (0-12) Administrative worker Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Deane Anne Cuffe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5014 Pierce Avenue College Park, Maryland 20740 a. Informant's Name/Relationship (Type, Print) James F. Parsons -son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State emetery, crematory or other place 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Metropolitan Crematory 10/22/2004 Alexandria, Virginia ≜ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 21. Signatur of Finer A Service Licensee 4400 Powder Mill Road Beltsville, Maryland 20705 23d. Part 1. Epper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2□ No 1 Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year, To the Hospitel or Attending Phywithin 24 hours after death.
To tha Funaral Diractor: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 10/18/204 emuli 0101235489 (VA) 20 IND 30. Name and address of person why NATIONAL NAVAL MEDICAL CENTER completed cause of death (Item 23a) (Type, Print) MARK N. DAMIANO LT MC USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles Allen Pattison /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner umberland AlleGAN If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 6. Sex Social Security Number 214–32–3121 **Funeral** Days Hours 94 1 **X**M 2 □ F 1910 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County ttam 27 is marked other than "natural", or ttems 23s or 28s-f ehow other traumatic event, the Madical Examinar must be notified at XXYes 2 □ No Bloomington Garrett MD. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21523 United States Ave. Bruster Be Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: white 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2010 Specify: 3
☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction if Health and Mental Hygiene. Itam 27 is marked other than Developer unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Eva Pattison Russell Pattison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 161 Potomac Ave., Bloomington, Maryland 21523 Jeff Beard/ nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of H Important: If Ite any injury or ot XXBurial 2 Cremation 3 Removal from State Westernport Maryland Philos Cemetery * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland a 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lours **Physician** acute /Medical Due to (or as a consequence of): **Examiner** Generalized Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 250No completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No this 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Diractor: After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a To the Funaral L **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 021244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostbara 32. Registrar's Signature 31. Date filed (Month. State Registrar

State of Maryland / Department of Health and Mental Hygiene

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Maryland 21215-0036	pemilt. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f show any Injury or other treumatic event, the Medical Examinar must be notified at RABS.	ל ב	1 ☐ Never Merr 3 ☑ Widowed	ied 2 Married 4 Divorced	1 ☐ Yes If Yes, Giv Year or Da	е				Specify:		Specif		ite	
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<u>Ö</u>	Attending or deeth. Cotor: After by the fune		2 Accident	investigation	on			М	1 🗆	Yes 2 No					
Division	or Atte		3 ☐ Suicide 4 ☐ Homicide	6 Could not I	286. Place	of Injury - At ng, etc. (Spe	home, farm, cify)	street, fact	ory, office		28f. Location (5 City or Tow		er or Rure	l Route Nu	mber,
	To the Hospital or Attending Physicien: The lew within 24 hours after deeth. To the Funerel Director: After this cartificata has completely filled in by the funerel director, page 2:	DIESTI C	29a. Certifier (Check only one)	Certifying P	hysician: To the miner: On the be and mann	sis of exami	nowledge, de nation end/or	eth occurr investigati	ed et the tir on, in my o	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and madate and place,	anner as st and due to	ated. the cause	(s)
	Within To the complete		29b. Signature end	title of certifier					29c. Licens	se number		29d. Date signe	d (Month, i	Day, Year)	
	- >- 0			tolo	MARA	1			J.	1777	7	101	251	04	
		+	30. Neme end eddr	ess of herson who	completed caus	e of deeth /It	em 23e) (Tvr	e. Print)	U	137)	>			- /-	
				Johnson					troot	001-1	nd MD o	1550			
	State		31. Dete filed (Mon			egistrer's Sig		A CII	AD A	- Nakia	uu, YU Z	21550			
	Registrar			OCT 2	8 2004 b	For Sugar	v B	23	13.11						

DHMH 16 Rev 6/95

			1 = For State Registrar	State of	Maryland /	Depa Cer	artment rtificate	t of H e <i>of L</i>	ealth a Death	and Me	ental Hyg	iene	2004	35	014
	Physici	an	1. Decedent's Name (First, Middle, L	•						2	2. Date of Deat	th Day	Year	3. Time	of Death
	/Medi			ae ROBINS							CTOBER	21,	2004	10:	45p м
1	Examir	ner	4a. Facility Name (If not institution, gi 10719 TIMOTHY DRI		er)				Location of SPORT	of Death			County of Death	J.	
	Funeral	_			Age (In yrs. last t	pirthday)	If Under	1 Year	If Under		B. Date of Birth		9 Birthi	nlace (Star	te or Foreign
Ь	Director		198-56-7001	1⊠M 2□F	28	Yrs.	Months	Days	Hours	Min.	uly 6,	197	6 Penn	sylva	nia
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	wn or Lo	cation							الما الماء	07-11-7
	Maryl f etho	ro	Maryland Washing	ton	Wi11:										City Limits es 2XXNo
	r 28a-	irec	10e. Street and Number				10f. Zip (Code			1	0g. Citize	en of What Cour		
	th with	al D	10719 Timothy Dr	ive				2179	5			USA		,	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Menial Hygiene. Itam 27 is marked othar than "natural", or Itame 23a or 28a-f ehow other traumatic event, the Medical Evant as rougher profiled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Microcod	12. Was Decede Armed Force 1 XYes 2 If Yes, Give Year or Date	es? □ No		Was Decede f Yes, speci l ☐ Yes 2	ify Cubar	spanic Orion, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		4. Race - Americ Black, White, Specify: b1	etc.	,
5-0	72 ho	etec	15. Decedent's E (Specify only highest gi	ducation ade completed)	16	a. Deced	ient's Usual kind of work	l Occupa k done d	ition	of working		16b. Kind	d of Business/In	dustry	
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of work DO NOT use			o. Norking	·				
d 21	filled v Hygie othar t		0-12 17. Father's Name (First, Middle, Las			co	mpute	_		r's Name (First, Middle, N		omputer		
lan	should be filed within and Mental Hygiene. marked othar than imatic event, the M	To Be		Unknown							nn Robi				
Maryland	2 should be fand Mental I is marked or aumatic ever	_	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	g Address ((Street a	nd Numbe	r or Rural F	Route Number,	City or	Town, State, Zip	Code)	
	1 and 2 Health tam 27 l		JoAnn Davis - m	other	8	51 S	outh	Co1d	lbrool			ambe	ersburg,	PA	17201
altimore,	9 = 5		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [ery, cren	natory or oth	her place		. Oc			ation - City or To		
Him			' 4 ☐ Donation 5 ☐ Other (Special Signal Land Funeral Service Lice		Cedar	r Lav	wn Mer	nori	al Pa	rk 27	,2004_	Hag	erstown	, Mar	yland
Ba	permit. Departr Imports any inj	ļ	2000	1100	Kunn	41	5 Eas	t Wi	1son	B1vd	., Hage	rsto	cal Home own, Mar	ylano	d 21740
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that care one cause on each	ine.									Approxim Interval B	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. 9un			ds(2) 0	FN	ecko	end Ho	2110		Onset an	d Death
	Examiner		1	Due to (or	as a consequence	e of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence	of):									
	cate be executed physician and the burial-transit	Examiner	that initiated events	C											
90,	oe exe	I Ex	resulting in death) Last	Due to (or	as a consequence	of):									
68760,	ficate be executed physician and s the burial-transit	edical		d											
Box 6	£ 00 00		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor					-			22	d Data of deline		
	0 0 0	ician/M	in the past 12 months?	4 Pregnant	2 Fetal deat at time of death		Ectopic pred Other (spec					230	d. Date of delive Month	Day	Year
P.0	that the de ed by the detached	Physi	9 Unknown	9Ll Unknowr											
	es un eq	by	Part II. Other significant conditions	contributing to death	n but not resulting	in the un	derlying cau	use giver	n in Part I.				contribute to th		
Ö	w requires been sign should be	leted								-	1 🗆 Yes	2 7	No 3□Proba	ably 4	Unknown
Vital Records,	e lar has	ompl									24a. Was an autopsy perform		24b. Were autop prior to con	sy finding opletion of	s available cause of
ta	ician: Th certificate rector, pag	e Co	25. Was case referred to medical		_						1/2 Yes 2	□ No	death?	2□ No	
<u>></u>	Physician: this certific ral director.	0 0	examiner?	Hospital:	atient 2 ER/O	utoatient	3∏ DOA	Other			Check only one		☐Other (Specify	1	
n of	ting Ph	Di: T	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Ir	njury 28b.	Time of	280	c. Injury a Work?			. Describe how			/	
sio	Attending ir death. actor: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be	n 10/21/	04 10	45	ЭМ	1 □ Ye	es 2 N				t sho		
Division	I or Attendater deati	Certification:	4 Homicide determined	28e. Place of	Injury - At home, f. etc. (Specify)		et, factory, o	office		28f.	Location (Stree City or Town,	State)	Vumber of Rural	Route Nu	mber, Dy
	e Hospital or 24 hours affe a Funaral Dir etely filled in		29a. Certifier 1 Certifying Pl	nysician: To the be	st of my knowledg	e death	occurred at	the time	date and	place and	dua to the one	LS PO	V+,M	<i>V</i>	
	I 4 II 0	edicai	(Check only 2X Medical Examone)	miner: On the basis and manner	i of examination ai	nd/or inv	estigation, in	n my opii	nion, death	occurred a	at the time, dat	e and pla	ace, and due to	the cause	(s)
	To the within 2 To tha complet	ž	29b. Signature and title of certifier				29c. l	License i					signed (Month, D		
}	\		· Caral A	allan	ud				OCME		O	CTOB	ER 22,	2004	
4	,5 ⁴¹		30. Name and address of person who	completed cause o				Stre	et, E	Baltin	nore, Ma	aryl	and 212	01	
	Sta Registr		31. Date filed (Month 2 2 6	2004 32. Redia	strar's Signature	1	este								
				- Trans	10.	14	were!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 35015 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Betty June Octobe 23 2004 15:02 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June Day Year 9 3 4 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF 217-32-5094 70 ΜĎ Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other then "neturel", or Items 23a or 28e-1 show other treumstic event, it e Madical Examinst must be notified at MD Washington Clear Spring, 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14026 Dry Run Road 21722 U.S.A. deeth v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Ie marked other then "neturel", or Ite ury or other treumatic event, Ite Madical Examina 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Beauty Salon Elementary/Secondary (0-12) College (1-4or 5+) Hair Stylist 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Wilbur Faith Sr. Helen C. Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) spouse 14026 Dry Run Rd. Clear Spring, MD 21722 Robert Lee Reed 20b. Place of Disposition (Name of commetery, crematory or other place)
Little Rose Hill 20c. Location - City or Town, State 20a. Method of Disposition Oct.2 2004 1 Burial 2 Cremation 3 Removal from State Clear Spring, MD permit. Page Department of Important: If any injury or once. Donation 5 ☐ Other (Specify) Fun Je Service Ligensee 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac arrhythmia minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or, injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XYes 2 No 3 Probably 4 Unknown Obstructive pulmon ary been sign Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has e 2 certificate has irector, page 2 Fo the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after c To the Funerel Direct completely filled in by 4 Homicide 29a, Certifier 1<mark>K Certifying Physicien:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Do058495

31. Date filed (Month, Day, Year) 2 5 2004 State Registrar

Buc

Williamsport, 14d 1. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

By

			For State Registrar	State of M	laryland / De	partmei ertifica			nd Mental H	ygien Reg. N	711114	350	116
	Physici	an	1. Decedent's Name (First, Middle, La Helen Virginia	Reed					2. Date of D Month	D	ay Year	3. Time o	of Death
	/Medic Examir		4a. Facility Name (If not institution, give)	4b. City	, Town, or	Location of	Octobe Death	-	6, 2004 c. County of Dea	4:55	P
			11406 Cam Court				nsin	gton			Montgor	nery	
	Funeral			Sex 7. A 1 □ M 2 ਉ F	ge (In yrs. last birtho Yrs	Months	Days	If Under 24 Hours	Min. (Month, L	ay, Year	7) Co	thplace (State ountry)	or Foreign
	Director		578-34-0316 Usual Residence of Decedent		90 '''				Dec.	27,1	913 Vir	ginia	
	arylan show det	_	10a. State 10b. County		10c. City, Town o	r Location						10d. Inside C	
	the M.	ecto	Maryland Montgor 10e. Street and Number	nery	Kensi		p Code			10a C	itizen of What Co		2 🙀 No
	3a or	Ϊ́	11406 Cam Court			101. 21		0895		10g. C	USA		
	death	nera	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	3. Was Dece			n? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Ame Black, Whit	nican Indian,	
36	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show the Medical Eraminat mast be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	No	1 ☐ Yes			Constituting the state of		Specify:	e, etc.	
21215-0036	2 hour	ted b	15. Decedent's E	ducation	16a. De	cedent's Usi	ial Occupa	ation		16b. I	Wh Kind of Business	nite Industry	
215	thin 7: e. an "n	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4or	- lii	ive kind of w e. DO NOT i	ork done d use retired	luring most o)	of working			•	
21	iled wi tygien her th		17. Father's Name (First, Middle, Last	2	Asse	mbly I	echn:		- None / Contact		Electi	conics	
anc	d be fi	o Be	John B. Long	,					s Name (First, Middi	_	•		
Maryland	shouf ind Me s mark umati	2	19a. Informant's Name/Relationship	Туре, Print)	19b. M	ailing Addres	s (Street a		aret Jo or Rural Route Num	hnso ber, City		Zip Code)	
Σ	and 2 Balth a n 27 ls		Margaret L. Frenc	ch Daugh	ter 114	06 Can	Cour	rt K	ensington	. Ma	ryland 2	20895	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event. The Medical Examination at the notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20h Blace of Di	anneition /Ale			Data		- mi	- 0	
Itim	it. Pa irtmen irtant: njury		'4 □ Donation 5 □ Other (Speci21. Signature of Funeral Service Lice		Mt. Zio the Bre	thren 22. Name a	Ceme	ery0c	t.20,2004	Lur	ay,Virgi	inia	
Ba	Depa Impo any i		Sol &	Xula	3	Franci	s J.	Colli	ns Funera	1 Ho	me, Inc.	. MD 20	001
	100		23a. Part1. Enter the a sease, or comshock, or part failure. List only	plications that cause one cause on each	d the death. Do not	enter the mo	de of dying	g, such as ca	1vd., W., S ardiac or respiratory	arrest,	r spring	Approximat Interval Bet	te
H	Physician		Immediate Caus: (Final disease or condition	a Conges	tive Hear	t Fail	ure					Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):							- AIRVILL	
		ier	Sequentially list conditions if any, leading to immediate	b. Athero	sclerosti s a consequence of):	c Hear	t Dis	sease				5 year:	s
	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	ai Ex	resulting in death) Last	Due to (or a	s a consequence of);								
687	fficate g phys	edicai		_ d									
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal death	3 □Ectopic p	reanana.			1	23d. Date of del	ivery	
	ie deal the att hed fo	/sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			5 Other (s					Month	Day '	Year
P.0.	that the de led by the a detached f		Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying	cause give	n in Part I.	23e. Did	tobacco	use contribute to	the cause of o	death?
Records,	quires tha n signed Ild be del	Completed by	Hypertension							Yes 2		obably 4 🗀	
000	≥ 0 ts	piete	Diabetes						24a. Wa		24b. Were au	topsy findings	available
Ä	ilclan: The law certificate has b rector, page 2 st	Com							per 1 Yes	opsy ormed? 2 🔀 No	death?	campletion of c 2□ No	anza oi
Vital	ding Physician: h. After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital:			Otho	P*	f Death (Check only				
of		٦. <u>۲</u>	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Inj (Month, D	and the same of th		OA Othe 28c. Injury Work	4 U Nursi	ing Home 5 X Res			cify)	
ion	Attending death. ctor: Afte y the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		a <i>y Year)</i> Inju	y M		? ′es 2∐No					
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Ir building, 6	ijury - At home, farm, tc. <i>(Specify)</i>	street, factor	y, office		28f. Location City or To	(Street a	nd Number or Ru e)	ral Route Num	ber,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Pl	veician: To the hes	t of my knowledge, d	aath coourse	Lat the tim	o data and	place, and due to the) and		
	ne Hospita 24 hours ne Funeral	Medical		miner: On the basis and manner s	of examination and/o	r investigation	n, in my op	inion, death	occurred at the time	, date an	d place, and due	to the cause(s	.)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License	number		29d. Da	ate signed (Month	n, Day, Year)	
	6		I (ilan W	wstra	- m		D0009	748		Octo	ber 18,	2004	
	`		30. Name and address of person who					11 1 0 -	F 013		100 00	000	
	Sta	te	Alan R. Weinstoc 31. Date filed (Month, Day, Year)		10313 Geo	orgia .	Avenu	ie #10	5 Silver S	pri	ng,MD 20	902	
	Registr		OOT 9 0 20	01 4	cas 19	ho	za Kar	/					

			For State Registrar	State of Maryl	and / De <i>C</i>	partment of H ertificate of I	lealth and M Death	Re	g. No.	35017
П	Physici	an	Decedent's Name (First, Middle, Last	•				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	James		in, IV			October	18, 2004	2:00 P M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of De	
	Formul		9810 Culver Cour 5. Social Security Number 6. S		yrs. last birthda	Kensin		8. Date of Birth	Montgom	ery inthplace (State or Foreign
П	Funeral Director			€7M 2□F	9 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 6, 1		Country)
			Usual Residence of Decedent		J			Jan. Ugi	900 MI	nnesota
	ylan		10a. State 10b. County	10c.	. City, Town or	Location				10d. Inside City Limits
	e Ma	cto	Maryland Montgom	ery	Kensi	ington				1 ☐ Yes 2 ☐ No
	15 th	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
	23a		9810 Culver Cour				20895		USA	
	tems Tems	Funerai	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp un, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
5-0036	within 72 hours after death with the Maryland ene. then "natural", or lfems 23a or 28e-f ehow the Madical Examinat nual be notified at	edt	15. Decedent's Ed	l	16a De	cedent's Usual Occupa	ation	1.	6b. Kind of Busines	White
5	In 72	Completed	(Specify only highest gra	de completed)	(Gi	ive kind of work done on DO NOT use retired	during most of work	ing	ob. Kilid of busines	smoostry
2121	r the	шо	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Writ	er/Photogi	rapher	Ma	arketing/	Consulting
ğ	be filed within 72 hours after death with the Marylan tal Hyglene. d other then "natural", or Items 23s or 28e-1 show event, the Medical Examinat must be coulded at	Be C	17. Father's Name (First, Middle, Last)		7 1122	2272110008	18. Mother's Name			on our cring
<u>a</u>	should be nd Mental marked o	To E	James A. Ronan,	Jr.		İ	Lucil	le Baur	nan	
Maryland	and he ma	٠.,	19a. Informant's Name/Relationship (Туре, Print)	19b. Ma	ailing Address (Street a	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
	and		Grace D. Ronan	Wife		Culver Co			Maryland	
altimore,	ages 1 and 2 should b nt of Heelth and Ment I: If Item 27 le marked f or other treumatic e		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	b. Place of Dis cemetery, c	sposition (Name of rematory or other plac Heaven	(e)	Date 2	Oc. Location - City of	r Town, State
Ě	Pages ment of ant: If It ury or o		' 4 ☐ Donation 5 ☐ Other (Specifi	(G.		Cemetery	Oct.	22,2004	Silver Sp	ring Maryland
Bail	permit. Page Depertment of Important: If any injury or once.		21. Signature of Funeral Service Licer	fsee	I	22. Name and ddres	ss of Facility Collins	Funeral 1	Home, Inc	
_	<u>0</u> 0 = € 0		Jus 20	ereo		500 Univers	sity Blvd	W,Sil	ver Sprin	g,MD 20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the c one cause on each line.	death. Do not o	enter the mode of dyin	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician	i i	Immediate Cause (Final disease or condition resulting in death)	a Glioblasto	ma Mult	iforme				14 months
	/Medical Examiner	. //	resulting in death)	Due to (or as a con	sequence of):					
		-	Sequentially list conditions,	b. Due to (or as a con	Securence of					
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (01 20 2 001)	ocquerioe oi).					
	al-tra	xar	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):					
68760,	The law requires that the death certificate be executed the been signed by the attending physician and bage 2 should be detached for use as the burial transit	edical		d.						
	ifficat g phy as th	edi								
Вох	eath certifi attending I for use as	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		3 □Ectopic pregnancy	,		23d. Date of de	elivery
m	deat ne atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant at time 9 □ Unknown		5 ☐ Other (specify)			Month	Day Year
о. О	that the de ned by the a detached t	Physician/M	9 🗆 Unknown							
	es th igned be de	by F	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cause give	en in Part I.			to the cause of death?
ord	w require been si should t	ted						1 U Yes	2 ½ No 3 ∏ F	Probably 4 Unknown
ec	has by	Completed						24a. Was an autopsy	prior to	autopsy findings available ocompletion of cause of
<u> </u>		Con						performe 1 ☐ Yes 2		s 2 No
Vital Records,	ysician: Th	Be	25. Was case referred to medical examiner?	Lleanital		Otto		(Check only one,		
ot	SOF	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 ☐ Inpatient : 28a. Date of Injury			4 🗆 indising ino		ce 6 ☐Other (Sp	ecify)
Division of	ding Phy h. After thi funeral	lon	1 Natural 5 ☐ Pending	(Month, Day Yea	r) 28b. Time Injur	y Worl	γat k? Yes 2 □ No	28d. Describe how	rinjury occurred	
2	or Attendi efter death. Director: A	ical	2 Accident investigation 3 Suicide 6 Could not be		At home farm			28f Location /Stre	net and Number or E	Rural Route Number,
<u>≥</u>	efter Dire	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	stroot, factory, office		City or Town,	State)	ista Houte Manpoi,
	spite		29a. Certifier 1 X Certifying Ph	ysicien: To the best of my	knowledge, de	eath occurred at the time	ne, date and place,	and due to the cau	ise(s) and manner a	us stated.
	To the Hospitel or Attent within 24 hours efter death To the Funerel Director: completely filled in by the	Medicai	(Check only 2 Medical Exer	niner: On the basis of exam and manner stated.	nination and/or	investigation, in my or	pinion, death occurr	ed at the time, dat	e and place, and du	e to the cause(s)
	To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in by	Me	29b. Signature and title of certifier			29c. License	e number	290	d. Date signed (Mor	nth, Day, Year)
i	1.1		Tame!	HSIMAL (40	D 0728	3.5		October 1	8, 2004
	17		30. No e and address of person who	completed cause of d th	(Item 23a) (Typ			,		
_			James A. Brown,			Center Dr	ive Rock	ville,Mar	ryland 2	0853
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	- P	/ .				
-	Registi	ar	OCT 2 0 200	4 Some		Sporks/				

State of Maryland / Department of Health and Mental Hygien 0 0 1 35018 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2004 **Physician** Oct. 13, Ahlers V. Robinson A M 4:41 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Oct 6, Birthplace (State or Foreign Country)
 Cu ba 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 85 070-44-3357 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral, or items 23a or 28a-f shov TX Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1703 East West Highway 20910 Jamaica Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Cuban Specify: Black 3X Widowed 4 ☐ Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Sewing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Importent: If item 27 is marked otheny injury or other traumatic even Be Alfred Wright ပ Diana Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Maple Avenue #1205, Takoma Park, MD Senorita Robinson (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 10/21/04 `4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Wash. D.C. 6. 23a. Perf. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cor Pulmonale disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Coronay Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Dav Year 4

□ Pregnant at time of death 5 Other (specify) detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? this certificate 1 Yes 2€ No 1 ☐ Yes X□ No Attending Physicien: 25. Was case reterred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the hours after deat meral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ŏ within 24 hours a 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) October 18, 2004 D 27865 3 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark K. Li, M.D. 1721 University Blvd., Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

21

2004

OCT

Steven C. Re 04-6912 AKG

эd	ı	Plea	ise Type or	Print in Black Inc	delible	lnk.	Ensu	ıre A	II Copies A	re Le	aible.	
	For State Registrar		State of	of Maryland / Depa	artment tificate	of H	ealth a	and N	Mental Hygid	ene (004	35019
n	1. Decedent's Nam	e (First, Midd	le, Last)						2. Date of Death Month	Day	Year	3. Time of Death
al		S	teven Cra	ig Reed					October	2Ś,	2004	12:25 P
er	4a. Facility Name (lf not institutio	n, give street and nu	mber)	4b. City, 7	Town, or	Location of	of Death		4c. Co	unty of Death	1
	110 Ales	sandra	Court #3	L47	Fre	deri	ick			Free	derick	
	5. Social Security N Unknown	lumber	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 50 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month, Pay, 1	1954	9. Birth Per	nplace (State or Forei intry) nnsylvania
	Usual Residence o	f Decedent										
	10a. State	10b. County	1	10c. City, Town or Lo	cation							10d. Inside City Limit

Funeral Director

Physicia /Medic Examin

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show yor jujury or other traumatic event, the Medical Everginar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Usual Residence of Decedent						
	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
ļo	Maryland Frederick	Fred	lerick				1 X Yes 2 □ No
ec	10e. Street and Number		10f. Zip Code		10g C	itizen of What Co	ountry?
	110 Alessandra Court, A	nt. 147	2170	2		J.S.A.	outing:
era	11. Marital Status 12. Was Decedent	-		ispanic Origin? (Specify Ye		14. Race - Ame	nican Indian
Ë	Armed Forces? 1 Never Married 2 Married 1 Yes 2		If Yes, specify Cuba	n, Mexican, Puerto Rican,	etc.)	Black, Whit	
Be Completed by Funeral Director	3 ☐ Widowed 4 🎇 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: W	hite
ete	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done in life. DO NOT use retired	ation during most of working	16b.	Kind of Business	/Industry
ompi	Elementary/Secondary (0-12) College (1-4or	5+) S	ales/Clerk)	De	epartmen	t Store
To Be C	17. Father's Name (First, Middle, Last) Robert J. Reed			18. Mother's Name (First, Mary Eli:	Middle, Maide	an Surname)	
	19a. Informant's Name/Relationship (Type, Print) Mr. Robert J. Reed, father			e Pike, Frede			
	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of cemeter	Disposition (Name of y, crematory or other place Ling Crematory	e) Date	20c.	Location - City or	Town, State
	21. Signature of Funeral Service Licensee	400255	Reeney Adn 106 East	i Basford PA Church St., I			21701
ompleted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or Injury that initiated events c.	a consequence of	of enter the mode of dying Lewer 1 Lewer 1 of):	g, such as cardiac or respir			Approximate Interval Between Onset and Death
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3☐Ectopic pregnancy 5☐ Other (specify)	as and graties of the control of the	to add continued to the	23d. Date of del Month	ivery Day Year
ed by Pr	Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause give	en in Part I. 23	e. Did tobacco	- "	the cause of death?
Complete					a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Be (25. Was case referred to medical examiner?			26. Place of Death (Check			
Jo.	1 ★ Yes 2 No Hospital: 1 □ Inpatie	nt 2 ER/Out	tpatient 3 DOA Other	ar: 4 Nursing Home 5 (Residence	6XXX ther (Spec	ily) at scene
ation;	27. Manner of Death 1 Natural 5 Pending (Month, Da 2 Accident investigation	ry 28b. T	njury Worl	at 28d. De	scribe how inj		
Certifica	3 □ Suicido 6 □ Could not be	ury - At home, far c. (Specify)	rm, street, factory, office	28f. Loc City	ation (Street a	nd Number or Ru te)	ral Route Number,
Medical Certification;	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	examination and	, death occurred at the tin t/or investigation, in my op	e, date and place, and due finion, death occurred at the	to the cause(e time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
Ň	29b. Signature and title of partitier	lh	29c. License	O.C.M.E.		ate signed (Month ober 26,	

Registrar

State

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed ca se of death (Item 23a) (Type, Print)

32. Registrar's Signature

S, R, L-31. Date filed (Month, Day, Year)

NOV 0 4 2004

State of Maryland / Department of Health and Mental Hygien 004 35020 State State Amend# 19b, perFH, FCHD, SL, 10 Perfilipate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Leonard Thomas Simpson 3:55 P M October 19, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
March 24,1925 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 → M 2 □ F 199-14-3003 79 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show in than "naturel", or Items 23a or 28a-f should be Medical Examinar must be notified at 1 Yes 2 No Maryland Frederick Director Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 Crown Street 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ≜Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other than any injury or other treumatic event, it a Market in the Mark in the Market in the M Elementary/Secondary (0-12) College (1-4or 5+) Electrician US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Simpson Mary Vitcuski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing ddess (Street and Number or Rural Route Number, City or Town, State Zip Code)

19b. Mailing ddess (Street and Number or Rural Route Number, City or Town, State Zip Code)

19b. Mailing ddess (Street and Number or Rural Route Number, City or Town, State Zip Code) Thomas Simpson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 10/23/2004 Mt. Airy, Maryland 21. Signature of Fureral Service Lic-22. Name and Address of Facility Stauffer Funeral Home 8 East Ridgeville Blvd. Mt. Airy, MD 21771 Part . Enter the disease, or complications that caused the coatt. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Distress 5 days /Medical Due to (or as a consequence of): **Examiner** 5 days Myocardial Infarction Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760 the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? res 2X No 1□ Yes Division of Vital or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural death, М 1 Tes 2 Accident within 24 hours after deat To the Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 402648900 10/20/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 15225 Shadygrove Rd., Dr. Odar Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra 2004

		For State Registrar	State of Mar		d / Depai		of He	ealth and		•		1004	350	22
Physicial /Medica Examine	n il	1. Decedent's Name (First, Middle, La Facility Name (If not institution, give	ne Sho	F	fer	4b. City. T	own, or t	Location of De		Date of D Month	2	ay Year	4 220	
Funeral Director		CCM 4 5. Social Security Number 6.5	Gex 7. Age (In yrs.	last birthday)	-	ak L	/	rs. 8.	Date of Bi (Month, D	irth Pay, Year	G-arne	4	
d 21215-0036 titled within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural", or itams 23e or 28e-f show ant, the Medical Examinar must be recilised at	ctor	10a. State 10b. County	rett	0c. Cit	y, Town or Loca		Oakla	and			10g C	itizen of What C		ity Limits 2 📉 No
23a or	a Dir	2999 Hutton Roa	d			101. Zip 1		1550			10g. C	USA		
5-0036 72 hours after death with the Marylan "natural", or itams 23a or 28a-f show sides! Examinar must be ricilified at	호	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev. Armed Forces? 1 □ Yes 2X No If Yes, Give Year or Dates:	erin U.		as Decede Yes, speci		panic Origin? , Mexican, Pue Specify:	(Specify erto Rica	/ Yes or N an, etc.)	0-	14. Race - Arr Black, Wh Specify:		
21215-0036 kd within 72 hours all gjene. er than "natural; or than "natural; or the Medical Exami	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		life. Do	ind of work O NOT use	(done du retired)	iring most of w	rorking			Kind of Busines		
E 8 = 0 ≥	To Be Co	17. Father's Name (First, Middle, Last Raymond Ro		er		Inter		18. Mother's N	ame (Fi	irst, Middle B e11	e, Maide	n Sumame)	of Agi dershel	Ü
e, Mary 1 and 2 sho Health and 1 sm 27 is me		19a. Informant's Name/Relationship (David H. Shaffer) 20a. Method of Disposition		20h D		Hutt	on R	nd Number or I		and,	Md.			
Baltimore, permit. Pages 1 as Department of Hea Important: If itam any injury or othe		20a. Memod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Service Licenter)	(y)	C	emetery, crema urora Co	atory or oth emete	ner place, : r y	10	/25/	04	Au	rora, W	V	
Balti permit. Departr Importa any inji		> Bielly NJ	Land									ral Hom [d. 2155		
76(icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	onseq	uence of):	en	len	arthi	hore	llo	tù	My	Interval Bet Onset and I	ween Death
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	by Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ 0 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	Fetel	ideath 3□E	ctopic pre Other (spe						23d. Date of de Month	•	/ear
ords, P.		Part II. Other significant conditions of	contributing to death but r	not resu	ulting in the und	lerlying ca	use given	in Part I.			tobacco Yes 2		o the cause of d	leath? Jnknown
f Vital Records, institute the law requires the law requires the secutificate has been signed director, page 2 should be considered.	Completed									24a. Was auto perfe 1 Yes		death?	utopsy findings completion of c	available ause of
f Vita ysiciar ysiciar is certif directo	o ne	25. Was case referred to medical examiner? 1 ☐ Yes No	Hospital: 1 Inpatient	200	ER/Outpatient	3 DOA	Other	26. Place of De 4 ☐ Nursing				6 ☐Other (Spe	əcify)	
Division of To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral documpletely filled in by the funeral death.	Certification:	27. Manner of Death Natural 5 Pending Pend			28b. Time of Injury	М		at es 2 □ No				ury occurred		
Division of the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certifi	4 Homicide determined		Specify	v)			data and slav		City or To	wn, Stat	'e)	urai Route Num	ber,
ha Hos n 24 hc ha Fun pletely	edical	(Check only 2 Medical Exer	niner: On the basis of example and manner states	caminal	tion and/or inve	stigation, i	n my opii	nion, death occ	curred a	it the time,	date an	of place, and du	e to the cause(s)
To t Vithi To t	Σ	29b. Signature and title of certifier	L/Gus.	ı	7/	29c.	License	6180	1			ate signed (Mon	/	
le		30. Name and address of person who	completed cause of deat	th (Item	23a) (Type, Pr	rint)	1	51. Fu	'X-	1 /	7.61	1 1 4.	104 D 215-9	>
State Registra		31. Date filed (Month, Day, Year) OCT 2 5 2	32. Registrar's	Signa	ture	OUL B	* N	16, 101		1,0	al-C	upol oc	1 -179	<i>. U.</i>

		1 - State of M Registrar		ertificate of Dealt		ntal Hygie	Z 11114	35023
Physici	ian	Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
/Medi		Dolores Eileen Shipley			(October	22 2004	11:40 PM
Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locat			4c. County of Death	
		301 S. Conococheague St. 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday		amsport	Date of Birth	Washing	
Funeral Director	1	215-26-1723 1□ M 2□XF	7.4 Yrs.	Months Days Hou	urs Min.	Date of Birth (Month, Day, Ye Ine 26.1		lace (State or Foreign try) ryland
ъ.		Usual Residence of Decedent	17			2116 20,1		•
arylar show	_	10a. State 10b. County	10c. City, Town or L				1	0d. Inside City Limits 1XX es 2 □ No
Ba-f	ecto	Maryland Washington	Wil	liamsport				
with the or 2	급	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	itry?
eath	eral	301 S. Conococheague ST 11. Marital Status 12. Was Decedent		2179 Was Decedent of Hispanio		y Yes or No-	USA 14. Race - Americ	an Indian
r Item	Funeral Directo	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes XX	No	If Yes, specify Cuban, Mex	xican, Puerto Rio	an, etc.)	Black, White,	
ours a	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Spe	ecify:		Specify: Wh	ite
72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupation e kind of work done during in DO NOT use retired)	most of working	168	. Kind of Business/Inc	dustry
Mithin hen	I du	Elementary/Secondary (0-12) College (1-4or	5+) life.				D 4	
Hed v		12 17. Father's Name (First, Middle, Last)		Cook	Anthor's Name /F	First, Middle, Maid	Restau	rant
d be d be sontal to eve	o Be	Gerald Abraham Barnhart						lls
shoul nd Ma mari mati	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street and Nu				
alth a		Thomas I. Shipley - Son	155	N. Humphrev	Oak Par	k,lllin	ois 60302	·
of Hei		20a. Method of Disposition	20b. Place of Disp		Date		. Location - City or To	
Page nent (ant; M		1) Sunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		n Mem. Park	Oct.27.	2004 Wi	lliamsport	.Marvland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show spiritury or other treumatic event, the Medical Exam for must be inclined at once.		21. Signature of Funeral Service Cicenses	O	Shorne Apuneta 25 S. Conoco	afity Home,	P.A.	•	21795
		23a. Part1. Enter the disease, or complications that cause	the death. Do not en				Trainsport,	Approximate
Physician		shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	iva	1 1000 +0	art.	/		Interval Between Onset and Death
/Medical		resulting in death)	a consequence of):	Merc	15/6		2 5	montry
Examiner		Sequentially list conditions. b	Mu	ng co	MCO	1.	3	Emonth
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
xecut end il-tran	хал	that initiated events	a consequence of):		 			
ficate be executed in the physician end streets the burial-transit	ia E							
ifficate g phy as the	edlcal	0.		•				
h cert endin	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		□Ectopic pregnancy			23d. Date of delive	
ed for	sicia	1 Yes 2 No 4 Pregnant a		Other (specify)			Month	Day Year
at the	Phy	9 Unknow,						
The law requires that the death certified has been signed by the attending page 2 should be detached for use a	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the i	underlying cause given in Pi	art I.	1 Nes	co use contribute to th	e cause of death? ably 4 □Unknown
k requ	Completed					24a. Was an		
vital nec sicien: The law s certificate has b firector, page 2 s	d m					autopsy performed	? death?	psy findings available apletion of cause of
en: T	ပိ	25. Was case referred to medical		26 D	Place of Death (C	1 Yes 2	No 1 □ Yes	2 No
ysicii is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	Othor	Nursing Home		6 □Other (Specify)
ng Ph ter th	1.	27. Manner of Death 28a. Date of Inju	y Year) 28b. Time (of 28c. Injury at Work?	28d	. Describe how in	njury occurred	
eath. or: A	catle	^ℓ 2 Accident investigation		M 1 ☐ Yes 2	2 □No			
or Att	Certification:	determined 286. Place of III	ury - At home, farm, st c. <i>(Specify)</i>	treet, factory, office	28f.	Location (Street City or Town, St	and Number or Rurai ate)	Route Number,
spitel ours a nerel I		29a. Certifier Certifying Physician: To the best	of my knowledge, dea	th occurred at the time, date	e and place and	due to the cause	a(s) and manner as st	atod
To the Hospitel or Attending Physicien: The Within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the tuneral director, page	edical	(Check only and manner st	f examination and/or in	nvestigation, in my opinion,	death occurred	at the time, date	and place, and due to	the cause(s)
To t withi To t	Σ	29b. Signature and title of certifier	1	29c. License numb	ber	29d.	Date signed (Month, L	Day, Year)
m		Mud Harno	lan, 1	10 D46	47	3 1	10/25	104
SHI		30. Name and address of person who completed cause of c	leath (Item 23a) (Type	Print)	001	1 0-	- Hag	erstown
Sta	ate	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	11) 1100	OFF		i m	21740
Regist		UUI 2 5 2004	un A. p.	perke				

			1 - For State Registrar	State of Mar	yland / De	partmen	of Health and of Death	Mental Hy	giene	2004	35024
	Dhunisis		1. Decedent's Name (First, Middle,					2. Date of De	eath η Day	V Year	3. Time of Death
	Physicia /Medic		Mary	Madeline	St	ewart		000	ber	-21 aa	04 245PM
1	Examine		4a. Facility Name (If not institution,	1 . 3 .	٠,	4b. City,	Town, or Location of Dea	ath	4c.	County of Death	1 0
			tanner-	leady Nu	nsing	Home	Pans	2000	U	wsn'	maty)
	Funeral		5. Social Security Number 213-18-8785	6. Sex 7. Age (a	In yrs. last birthb 84 Yrs	Months	1 Year If Under 24 Hr Days Hours Mir	n. (Month, Da	rth ay, Year)	9. Birth	pplace (State or Foreign untry)
	Director		Usual Residence of Decedent				-	January	10,	1920 P	eńnsylvania
	yland		10a. State 10b. County	1	Oc. City, Town or	Location					10d. Inside City Limits
	a-fs	ctor	Maryland Wash	nington	Boon	sboro					1 ☐ Yes 2X No
+	or 28	Oire	10e. Street and Number			10f. Zip			-	izen of What Cor	untry?
-	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Exarcative must be notified at	Funeral Director	8507 Maplev				21713			J.S.A.	
2	er de Items	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	Was Deced If Yes, spec	ent of Hispanic Origin? (ify Cuban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	0-	 Race - Amer Black, White 	
38	rs aft	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	od 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:			Specify: Wh	ite
3+C	2 hou	ted	15. Decedent's	s Education	16a. De	cedent's Usua	I Occupation		16b. Ki	ind of Business/I	
218	within 7. ene. then "n	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(G lif	ive kind of wor e. DO NOT us	I Occupation k done during most of w e retired)	orking			
72	er the	Completed by		1		Steno	grapher		U.S	. Gove	rnment
and	be file tal Hy d oth	Be (17. Father's Name (First, Middle, L.				18. Mother's N	ame (First, Middle	, Maiden	Sumame)	
-5	should nd Men marka marka	2	William	В.	Stew		Bert		Ra		tottlemyer
Man	C1 c2 = E		19a. Informant's Name/Relationsh Jo-An L. Mar				(Street and Number or F				
	1 and Health em 27 ther tr		20a. Method of Disposition		Part and the second second	/ ROSE	B HIII AVE	Date H		Stown, ocation - City or 1	Md. 21740
ام کے	0 0 = =		₩ Burial 2 Cremation	2 PLANOATINOM 2/4/6	20b. Place of Di cemetery,	rematory or of	her place)			-	
M\C altimore,			* 4 □Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		HOSE H						n, Marylan
Ba	permit. Departr Importu any inju		-R. hnol	Ruder		Andrew	K. Coffman	Funeral	Hom	e, Inc.	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that caused the	e death. Do not	4U Eas enter the mod	t Antletam of dying, such as cardi	St., Hage	rsto	wn, Mary	/land 21740
	Dhysisian		Immediate Cause (Final	nly one cause on each line.		4.0					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ONGE Due to (or as a c	consequence of):	TEA	2+ FAILUI	LE			157
	Examiner				,						_
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events	Due to (or as a c	consequence of):						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
760,	te be executed ysicien and e buriat-transit		resulting in death) Last	Due to (or as a c	consequence of):						
6876	2 2 2	dicai	,	d							
9 ×	leath certificat attending phy	Physician/Med	IF FEMALE:	23c. If yes, outcome of	nregnancy						10
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 [4□Pregnant at tir	Fetal death	3 ☐Ectopic pro			1	23d. Date of delik Month	Day Year
P.O.	that the de ted by the a detached t	ysie	1 ☐ Yes 2 🎉 No 9 ☐ Unknown	9□ Unknown	.0 01 002,11	O Cirior (apr	schy/				
σ.		by Pt	Part II. Other significant condition	is contributing to death but i	not resulting in th	e underlying ca	tuse given in Part I.	23e. Did 1	tobacco u	ise contribute to	the cause of death?
rds	w requires to been signer should be considered.	q pe						1 🗆	Yes 2	□No 3□Pro	babiy 4 Munknown
000	law rec as bee 2 shor	Completed						24a. Was		24b. Were aut	opsy findings available
æ	The lav	шо						auto perfo 1 ☐ Yes	ormed?	prior to death?	ompletion of cause of
ital	icien: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Place of De	eath (Check only		10165	2 140
>	× ≤ = = = = = = = = = = = = = = = = = =	70	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	tient 3 DO	A Other: A ursing	Home 5 ☐ Resi	idence (6 □Other (Spec	ify)
0	ng PI		27. Manner of Death 1 DaNatural 5 □ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Time Injur	e of 2	Bc. injury at Work?	28d. Describe	how injur	y occurred	
Division of Vital Records,	i or Attending Phater death. Director: After the in by the funeral	Certification:	2 Accident investigation inve	ation of he		М	1 ☐ Yes 2 ☐ No				
Ξ	after d Direct	rtifi	4 Homicide determine		- At home, farm, (Specify)	street, factory	, office	28f. Location (City or To	Street an wn, State	d Number or Rui }	ral Route Number,
	pital ours a eral [29a. Certifier 1 X Certifying	Physician: To the best of	mu knowledge d	acth activities					
	To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical E	Physician: To the best of r examiner: On the basis of ex and manner state	camination and/o	r investigation,	in my opinion, death occ	curred at the time,	date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c	License number		29d. Dat	e signed (Month,	, Day, Year)
	- > - 0) (2-6		1	55153		1	0/22/0	4
	a		30. Name and address of person w	nho completed cause of dear	th (Item 23a) (Ty					1 - 1	1
2	24		Khalid M.	Waseem M.	0		Court, Hag	erstown,	Mar	yland 2:	1740
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2	32. Registrar's	Signature	Angel	,				
	riegistr	वा	VVI A	W LUUT MENERIA	17.	SHORAGE	7				

10/01/04 State

HD

31. Date filed (Month, Day Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

HOPRA, MD. 600 Ridgel

2004

32. Registrar's Signature

			State of Marylar For State of Marylar State of Marylar 1. Decedent's Name (First, Middle, Last)	nd / Depa		leaith and I	Mental Hyg	2 U U 4 Reg. No.	35026
	Physici /Medio Examin	al	Moufadi Saddy 4a. Facility Name (If not institution, give street and number) University of Manyland Medical	Center	Balton	r Location of Death		Day Year 20 2004 4c. County of Death N/A	3. Time of Death
	Funeral Director		218-13-7607 Usual Residence of Decedent	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Jan. 1		place (State or Foreign ntry) Syria
	ith the Marylan or 28e-f ahow e notified at	Oirector	10a. State 10b. County 10c. Ci 10aryland Montgomery 10e. Street and Number	ty. Town or Lo	mantown 10f. Zip Code			10g. Citizen of What Cour	10d. Inside City Limits 1X Yes 2 □ No ntry?
960	s 1 and 2 should be filed within 72 hours efter deeth with the Maryland Heelth and Menlel Hygiene. Item 27 is marked other than "naturel", or Iteme 23a or 28e-f ahow other treumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	13973 Lullaby Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		208 Was Decedent of H If Yes, specify Cuba		pecify Yes or No- p Rican, etc.)	Specify:	
21215-0036	d within 72 ho giene. Ir than "natu Ire Medical	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wor d)	king	16b. Kind of Business/In Syrian Mili	·
Maryland	2 should be filed withir and Mentel Hygiene. Is marked other than eumatic event, the Ms	To Be C	17. Father's Name (First, Middle, Last) Salin Saddy 19a. Informant's Name/Relationship (Type, Print)			18. Mother's Nam Myrian	l	Maiden Sumame) Dham	
Baltimore, Ma	t. Page rtment o rtent: if njury or		Fahmieh Mary Soddi/daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 MRemoval from State Method of Disposition 1 Methods 1 Methods 1 Methods 2 M	13973 Place of Dispondent of the Dispondent of t	B Lullaby sition (Name of matory or other place tan Gree Cemetery 2. Name and Ad re	Road Ge	ermantown Date	r, City or Town, State, Zign, Maryland 20c. Location - City or To Khabab, Sy:	20874 own, State
B	Physician /Medical Examiner		23a. Part Lenter the disease, or complications that caused the dea shoot or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sep 5.5 Due to (or as a consection)	957] z th. Do not ent	+11 Annap	olis Road	l_Odent	rematory, Pon. Maryland	Approximate Interval Between Onset and Death
8760,	be executed ician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Butter in Due to (or as a consect of the c	quence of):	preur	ennia.			
P.O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of constitutions of the pregnant at the pregnant at time of constitutions of the pregnant at time of constitution	al death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of delive Month	ery Day Year
Records, P	w requires thet the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not res		nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to the	he cause of death?
Vital Rec	The la ate has page 2	e Completed	25. Was case referred to medical			OC Place of Dag	24a. Was a autop: perform 1 Yes	sy prior to co med? death? 2 No 1 ☐ Yes	psy findings available mpletion of cause of
Division of Vi	ng Phys Iter this	Certification; To B	examiner? 1 Yes 25 No 27. Manner of Cath 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined.	ER/Outpatier 28b. Time of Injury	f 28c. Injur War M 1	er: 4 ☐ Nursing H	ome 5 Reside	ence 6 Other (Specification of the control of the c	
Div	To the Hospitel or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the to	edical Certi	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)	fy) owledge, deatl	h occurred at the tin	ne, date and place, pinion, death occur	City or Town	n, State)	hates
	To the within 2 To the complet	Med	29b. Signature and title of certifier Aud 11 Properties August 12 Properties August 1	le t	29c. Licens		2	29d. Date signed (Month,	
	2300		30. Name and address of person and completed cause of death (Iter Paules Shark WD 22 31. Date filed (Month, Day, Year) 32. Registrar's Sign.	S. Gre	Print)		hore n	m 21201	
	Sta Registi		OCT 2 1 2004		had.				

DHMH 17 Rev 1/2001

DAI

DAN	HEL M.	SC	FOR	State of	Marylan		artment of H		Mental Hyg	iene	35027
			State Registrar 1. Decedent's Name (First, Midd	de. Last)		Cer	tificate of L	Jean	2. Date of Deat	eg. n2 0 0 4	3. Time of Death
	Physici		DANIEL MORRI						Month OCT.	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution WASHINGTON ADV	on, give street and num			4b. City, Town, or TAKOMA			4c. County of Do	eath
	Funeral		5. Social Security Number		7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		214.48.7900	1⊠M 2□F	77	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 1	, 1927 In	ıdia
	and wo		Usual Residence of Decedent 10a. State 10b. County	у	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary I-1 sh	tor	Maryland Prince	ce George's	нуа	attsvi	11e				1 ∰Yes 2 ☐ No
	th the	irec	10e. Street and Number		1		10f. Zip Code		1	0g. Citizen of What	Country?
	ath wi	ral	7302 Riggs Roa				20783			U.S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show many injury prother traumatic avant, the Marical Examiner must be nailited at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☒ Divorce	If Yes Give	ces? 21⊠No e	1	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2█ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Black, W	merican Indian, thite, etc. Asian
5-0	72 ho	Completed	15. Decede (Specify only highe	int's Education est grade completed)		16a. Deced	tent's Usual Occupa kind of work done d OO NOT use retired)	tion uring most of wor	king	16b. Kind of Busine	,
121	within ene. than "	mpl	Elementary/Secondary (0-12)		4or 5+)		00 NOT use retired) natologist			Healthcan Services	ce
	Hygie Hygie Sther I		17. Father's Name (First, Middle	5+		пеш	atorogra		ne (First, Middle, M		
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "r traumatic avant, the Mas	To Be	M. Solomon					Mariamm	a	(Unobtai	nable)
ary	and Normal		19a. Informant's Name/Relation							City or Town, State	
	and sealth m 27		Nina Chandra	Solomon/Dau		-	The second secon	1 TO 10 THE R. P. LEWIS CO., LANSING, MICH. 40 THE R. P.			
Baltimore,	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State For	emetery, cren	sition (Name of natory or other place coln Ceme	ery 10/2		20c. Location - City Brentwood	or Town, State , Maryland
Balt	permit. Departr Imports any inje		21. Signature of Funeral Service	License	tre	H]	. Name and Addres INES-RINAI .800 New I	s of Facility LDI FUNEI Hampshire	RAL HOME	ilver Spr	ing, MD 20904
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cast only one cause on ea	used the death	Do not ent	er the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cett	erwell	crotic	Cerdior	male	Discus		Oriset and Death
	/Medical Examiner			Due to (d	or as a consequ	uence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a consequ	uence of):					
	icuted nd transit	Examiner	that initiated events	C							
68760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (d	or as a consequ	uence of):					
687	ficate p phys	edical		d							
.O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of a Month	delivery Day Year
<u>α</u>	signed by	þ	Part II. Other significant condit	tions contributing to de	ath but not resu	ulting in the u	nderlying cause give	n in Part I.		pacco use contribute	e to the cause of death? Probably 4 Minknown
Records,	> 0 0	lete							24a. Was a	n 24b Were	autopsy findings available
	The lav	Completed							autops perform 1 X Yes 2	y prior t ned? death	to completion of cause of
Vital		BeC	25. Was case referred to medic examiner?	al				26. Place of Dea	th (Check only on	~	63 2 100
of V	Physician: rthis certific ral director.	To	1 X Yes 2 □ No			ER/Outpatien		4 Linuising m		nce 6 Other (S	pecify)
on c		lon:	27. Manner of Death 1 De Natural 5 ☐ Pend		f Injury n, Day Year)	28b. Time of Injury	Work	at ? ′es 2 ∐No	28d. Describe ho	w injury occurred	
Division	Attending r death. actor: Afte	ficat	3 ☐ Suicide 6 ☐ Could		of Injury - At ho	me, farm, str	eet, factory, office	95 2 140	28f. Location (St	reet and Number or	Rural Route Number,
ō	al or A s after if Dira	Certification:	4 Homicide	mined 200. Flace of buildin	ig, etc. (Specify	')	,,		City or Town		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (ring Physicien: To the bl Exeminer: On the ba and mann	sis of examinat						
	To th To th comp	M	29b. Signature and title of certific	ier			29c. License		25	9d. Date signed (Mo	
	20		Theolow	Hling	w.	_	0.C.	M.E		OCT. 1	L6, 2004
_	~		30. Name and address of person THEUDORE M.	King	1	11 Per		Baltimo	ore, Mary	vland 2120)1
	Sta Regist		31. Date filed (Month, Day, Yea	2004 32. Re	egistrar's Signa	ture \$	Sparks	/			

State of Maryland / Department of Health and Mental Hygiene 2004 35028 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 12:25 **Physician** OCT FREDERICK SEBURN 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hyattsville
If Under 1 Year | If Under 24 Hrs. PRINCE GEORGES 7000 Highview Terrace #002 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours Min **Funeral** 1 **3**M 2 □ F Yrs. 66 Sept. 28, 1938 137-30-4244 New Jersey Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1√2 Yes 2 No Pr. Director MD Geo. Hyattsville the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 7000 Highview Terrace, #002 20782 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 🌪 ☐ No Specify Specify: Black If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) Self-Employed Hydrolic Tech 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pearl Willy Co.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20782 Jesse Seburn 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra Loretta Seburn (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Surial 2 ☐ Cremation 3 ☐ Removal from State Rockville, MD Cem 10/22/04 Lincoln Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Funeral Service License 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 months Physician Pancreatic Cancer Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine to the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ▼ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After thi 27. Manner of Death Certification: 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide þ 4 Homicide within 24 hours af To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 29b. Signati 01 10-20-04 D53829 dress of person who completed cause of death (Item 23a) (Type, Print) 2527 Greenway Ctr Dr., Greenbelt, MD Kevin Shannon, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 1 2004 OCT Registrar

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and 2 s	alth en 27 is r er trau		JoAnn Jackson/ da	Hill Ro	ad, Raw	lings, Ma	arylar	ad 21557					
mit. Pages 1	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show samply injury or other traumatic event, the Medical Expirition must be incitined at once.		20a. Method of Disposition 1XXNBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	xe) (ex	20c. Location - City or Town, Stata Westernport Maryl.								
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	4		Dr. Jesus Tan,	Frostburg	g Plaza,	Frostbu	ırg,	Marylan	d 2153	2			
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State of Maryland / Department of Health and Mental Hygiene 2004 35030 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Arthur Henry Sanger 2004 Oct 1000 AM /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Corsica Hills Nursing Home Centreville Queen Anne 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 112 M 2□ F 220-26-2072 75 Director April 6, 1929 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow the Medical Examiner must be notified at 1€Yes 2 No Dorchester Maryland Cambridge Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bradford House, 701 Race St., Apt. 108 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ HO Specify: Specify: White ģ 3 Widowed 4 □ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other then Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 6 Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental h permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c Otto Sanger Florence Ziggler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rena Tuttle/Step-Daughter 500 Waverly Lane, Centreville, MD 21617 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) East New Market Cemetery 10/21/20 4East New Market. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ran-Bromwell Funeral Home, P.A. Cambridge, MD 21613 Part T. Enter the disease, of complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed -transit and physician at s the burial-t Due to (or as a consequence of) Physician/Medical attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy þ in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ses 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed page certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 NO P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 ANaturai 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after filled To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cogifie 29c. License number 29d. Date signed (Month, Day, Year) 26388 erson who completed cause of death (Item 23a) (Type, Print) 302 Collins Hurlock Md 21643 Michne State Registrar

Box 68760,

P.O.

Records,

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L	/Medic	åal	Mildred Mae Short 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	19 2004 3:15 A M 4c. County of Death
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r	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	If I Index 1 Vear If I Index 24 Hrs	8. Date of Birth	
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	o the	Med	29h Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
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			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		^
	40.00		NOMAN THANKUY 300 AUROR	A STREET CAME	RIDGE	MD 21613
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type NOMAN THANKY 300 AUROR 31. Date filed (Month, OCTAT) 2 1 20042. Registrar's Signature	books		
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35032 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Anita Marie Sparta October 18, 2004 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Clinton

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Min. (Month, Day, Year)
Sent. 1, 19 Southern Maryland Hospital Prince George's 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 20F Yrs. Director 213-82-1789 44 1960 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1614 Pin Oak Drive or items 23a 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: if item 27 is marked other than "natural", or item Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Theodore Joseph Sparta Eva Anita Pero 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other trait Once. Louise V. Sparta - Sister 1614 Pin Oak Drive, Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 10-20-2004 Waldorf, MD 22 Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 21. Sign were of Funeral Service Licensee M00053 okoum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician - Cli disease or condition resulting in death) /Medical Due to (or as a consequence Examiner d Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Cther: 4 🗆 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify) ို 1 ☐ Yes 25 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending n 24 hours after death.
he Funeral Director; A
bletely filled in by the ft death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 200 D24208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Abulhasan U. Ansari, 8926 Woodyard Road #101, Clinton, MD 20735 OCT 2 1 2004 31. Date filed (Month, State Registrar

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State of Maryland / Department of Health and Mental Hygiene 2004 35034 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Kenneth Wilson Thomas, Sr. October 22, 2004 ann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 10041 Melody Lane Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Days Hours 88 717-12-3118 Mary Land Oct.14,1916 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Itam 27 is marked other than "naturel", or flems 23a or 28a-f show other traumatic event. I're Medical Exeminer must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 10041 Melody Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 KNo Specify: Maryland 21215-0036 Specify: Completed by 3 XWidowed 4 ☐ Divorced White 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Furniture Manufacturer Upholsterer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be of Health and Menta Minnie A. Dorsey Howard B. Thomas ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10041 Melody Lane Hagerstown, MD 21740 Kenneth W. Thomas, Jr. - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 0 permit. Page Department Important: fi any injury or 4 Donation 5 Other (Specify) Greenlawn Mem. Park 110-25-2004 | Williamsport, Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Suneral Service Ofer 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediaty Cause (Final disease or condition resulting in death) Altrevosclerofic Cardiovascular Disease **Physician** MIINS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ed by the atter detached for u Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1 Yes 2 No certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Medical Certification: After Hospital or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide filled in by 4 \ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28365 10 -22-041 941 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerst-own 368 mill 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Of Ut

35035

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inopartment of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural; or itema 23a or 28a-1 show any injury or other traumetic event, the Madical Examination with be multiplied at once.

Baltimore, Maryland 21215-0036

TUTT, RONALD

Pnysician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial filector, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

State Registrar

	Decedent's Name (First, I	Middle, Las	t)							2. Date of De Month		av	Year	3. Time of Dea	ath
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	5. Social Security Number	6. Se		ge (In yrs.	last birthday	/) If Unc	der 1 Year is Days		er 24 Hrs. s Min.	8. Date of Bi (Month, Di	rth			place (State or Fo	reign
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	Yvette Matthews/Daughter 1245 Faraday Pl. N.E. Washington, D.C.											C. 20	0017		
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n nala										1 🗆	Yes :	No	3 🗌 Prot	pably 4 □Unkn	own
ble										24a. Was		24b.		psy findings avail	
d line											psy ormed? 2 N		prior to co death? 1 \(\text{Yes}	mpletion of cause	of
b	25. Was case referred to me	edical						26. Pla	ice of Death	1 Yes		0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20140	
2	examiner? 1 √ Yes 2 □ No		Hospital:	ent 2 🖫	ER/Outpatie	ent 3⊡ [DOA Ott			me 5 ☐ Resi		6 ∏Oti	her (Specia	iv)	
	27. Manner of Death 1 Natural 5 P	ending	28a. Date of Inju (Month, Da		28b. Time Injury		28c. Inju Wo	ry at rk?		28d. Describe				,,	
Can	2 Accident in	vestigation ould not be				М	1 🗆	Yes 2	□No						
cer micanoni		etermined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
2	29a. Certifier 1 Cer	rtifying Phy	vsician: To the best	of my kno	wiedge, dea	ith occurre	ed at the ti	me, date	and place	and due to the	causa/	s) and m	anner ac c	tated.	
ealcai	(Check only 2 Med one)	dical Exam	iner: On the basis of and manner st	of examina	tion and/or in	nvestigatio	on, in my	pinion, d	eath occurr	ed at the time,	date ar	nd place,	and due to	the cause(s)	
Ē	29b. Signature and title of ce		77			2	9c. Licens		/		29d. D	ate signe	ed (Month,	Day, Year)	
80	141	M	Keus	1			1)/	94	46			10/1	9/00	j	

A.D. 575 PLAIN STREET, SUITE 357, LAURE, MD 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.D.

STEVEN 5. REMSEN
31. Date filed (Month, Day, Year)
OCT 2 1 2004

			1 - State Registrar	State of Ma	aryland	l / Depa <i>Cer</i>	rtment of F tificate of	lealth a <i>Death</i>	and Men	ntal Hyg R	jierze) () 4	35036
	Dhuaisi		1. Decedent's Name (First, Middle, Las	1)						Date of Dear	Day	Year	3. Time of Death
	Physicia /Medic		EDWARD FRANKL		·				0	ctobe	r 16, 2	2004	1:27 P ^M
	Examin	er	4a. Facility Name (If not institution, give Holy Cross Hospita	ŕ			4b. City, Town, o			y of Death			
	Francis		5. Social Security Number 6. Se		e (In yrs. la	st birthday)	Silver If Under 1 Year	If Under 2		Date of Birth		gomer 9. Birthp	place (State or Foreign
	Funeral Director			X M 2□F	74	Yrs.	Months Days	Hours	Min. Ja	Date of Birth Month, Day an 10	,1930	Cour	ginia
	p .		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation					1	10d. Inside City Limits
	Aaryla I shov	ō	Md. Montgo	ma r v		kvill						[1 ☐ Yes 2X No
	28a-f	rect	10e. Street and Number	пету	ROC	-KVIII	10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
	3a or	Funeral Director	4801 Macon Road				20852				United	Stat	tes
	death	nera	11. Marital Status	12. Was Decedent E	Ever in U.S	i. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Orig	gin? (Specify	Yes or No-		ce - Americ	
92	or life		1 Never Married 2 Married	1 ∐ Yes 2 X N If Yes, Give	No		□Yes 217 No		, , , , , , , , , , , , , , , , , , , ,	, στοι,	Specia		nite
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or llems 23a or 28a-f show fra Modical Extraiter anat be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		16a Decec	lent's Usual Occu	nation			16b. Kind of E		
5	iln 72 n "na n "na	plet	(Specify only highest grad	de completed)		(Give	kind of work done OO NOT use retire	during most	t of working		TOD. TAILS OF E	703111033411	dustry
N	d with giene er tha	mo	Elementary/Secondary (0-12)	College (1-4or 5-	1+)	Drywa	11 Contr	actor			Const	ructi	Lon
g	be filed v tal Hygie d other i	Be (17. Father's Name (First, Middle, Last)								Maiden Sumai	me)	
<u> </u>	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene is and Mental Hygiene is marked other than "naturel", or litems 23a or 28a-1 show termatic event, the McMcal Extendent chart be notified a	ဥ	James Henry Tharp	Diana.		405 44-15	444 (0)		ie Fry			01-1- 7	
Maryland			19a. Informant's Name/Relationship (7) Thelma A. Tharp (1)	•			g Address (Street Macon R				id. 208) Code/
ē,	t and Health Hem 27 Jother to		20a. Method of Disposition	VII C)	20b. Pla		sition (Name of natory or other pla		Date	253	20c. Location		own, State
Ë	Pages ent of nt: # ii		1 N Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify				Mem. Par	•	Oct. 2 2004	.0,	Rockvil	lle, 1	Md.
Baltimore,	permit. Pages 1 Department of H Importent: If itel any injury or ott		21. Signature of Funeral Service Licen	Dry	,		Name and Addre		DC VO.		ral Ho		id. 20877
			23a. Part1. Enter the disease, or comp	olications that caused	the death.							Ig, II	Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	a Ventric		'achve	ardia						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a			arura		-				
	Examiner		Sequentially list conditions,	D		tery Syn	drome						
	ed sit	ılner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hypertension Due to (or as a consequence of):										
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8760,	cate be executed physician end the burial-transit	dical		d									
9	ng ph	Medi	IF FEMALE:										
Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death certific relath. relath. sctor: Atter this certificate has been signed by the attending by the tuneral director, page 2 should be detached for use as	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal	death 3□	Ectopic pregnanc	y			1	ate of delive	ery Day Year
o O	he de / the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of dea	ath 5L	Other (specify) _						·
σ.	that the poly	y Ph	Part II. Other significant conditions co	ontributing to death bu	ut not resul	ting in the ur	nderlying cause gi	ven in Part I.		23e. Did tol	bacco use con	tribute to th	he cause of death?
rds	quires in sign									1 🗆 Ye	es 2□No	3 🗌 Prob	pably 4 XUnknown
000	aw requirass been si 2 should l	plet								24a. Was a autops		Were auto	opsy findings available impletion of cause of
m m	ysicien: The lav is certificate has director, page 2	Completed								perform	med?	death?	
/ita	icien: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	Hereitel			100		of Death (Ch	neck only on	(e)		
of	Physi this o	. To	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 ☐ Inpatie		R/Outpatien 28b. Time of	I 3LI DOA				ence 6 □Oti		y)
on	ding Ph th. After th tuneral	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	Wo	rk?]Yes 2∐N		D0001120 110	on injury cocus	100	
<u>Visi</u>	r Attender death	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At hon	ne, farm, str	eet, factory, office		28f.	Location (SI City or Town	treet and Numi	ber or Rura	al Route Number,
Ö	tal or rs afte el Dir ed in	Certification:	4 - Homoloo	building, etc	o. (Specify)					ony or row	i, otale)		
	To the Hospital or Atteno within 24 hours after death To the Funerel Director: completely lilled in by the	edical	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred at the ti restigation, in my	me, date and opinion, deat	d place, and other than the control of the control	due to the ca t the time, d	ause(s) and m ate and place,	anner as st and due to	tated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licen			1	9d. Date signe		
	10		I bonte.	UE UE	=, CON	NE	606	19			Octobei	r 16,	2004
			30. Name and address of person who on the Connie Le M.I	completed cause of de	eath (Item :	23а) (Туре,	Print) Road Si	lver S	pring,	Md.	20910		
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 0 200	32, Registra		JI J	Sparks	/					

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 35037 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Α. Truong October 19, 2004 11:45 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Washington Adventist Hospital Takoma Park
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 1, 1929 6 Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 F 75 Director Jan. China 578-04-2439 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural, or items 23a or 28a-f shov The Madical Examiner must be notified at 1 ☐ Yes 2 🔀 No Montgomery Silver Spring Direct Maryland 10f, Zip Code 10g. Citizen of What Country? 9704 Belvedere Place 20910 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Asian Specify: 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home injury of other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be f nent of Health and Mental I out: If item 27 is marked of 2 Unknown Truong Shi Tang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dai Chau / Son 9704 Belvedere Place, Silver Spring, MD 20910 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan 20a. Method of Disposition October 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State permit. Pege Department (Importent: If any injury of any i * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Alexandria, Virginia Crematory 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licenses MD 20901 23a. Part1. Enter the disease, or complicixions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ore cause on each line. Immediate Cause (Final **Physician** neumonia resulting in death) /Medical Due to (or as a lonsequence of) Examiner 2 Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician a should be detached for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Gastric Cancer 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Fo the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature 29d. Date signed (Month, Day, Year) D-33482 October 20th, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M.D. 7343-A Hanover Parkway Greenbelt, Maryland 20770. Sajeer Anand

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

21

		State Registrar 1. Decedent's Name (First, Middle,	Last)	Cen	tificate of	Death			04 3503
Physic /Med		ROBERT	MICHAEL		TIPPET'			4 ^{Day} 00	
Exami		4a. Facility Name (If not institution, Univ. of Mary	yland Medica			Location of Death			ty of Deeth
Funeral Director	1	5. Social Security Number NONE Usual Residence of Decedent	5. Sex 7. Age (In	yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Heurs 15	8. Date of Birtl (Month, Day 6/4/04		9. Birthplace (State or Ford Country)
II X I X I 3-UU30 filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-f show int, the Madical Exemples must be notified at	Director	10a. State 10b. County MD. Anne		c. City, Town or Loc Glen Burn					10d. Inside City Lin 1 ☐ Yes 2★
with the		10e. Street and Number 1606 Lorime:	r Dd		10f. Zip Code 21061				f What Country?
ter death w items 23a	Funeral	11. Marital Status	12. Was Decedent Ever	r in U.S. 13. V		dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	USA 14. Ra	ace - American Indian,
5-UU30 72 hours after death with the Maryla "natural", or Items 23a or 28a-f sho oficel Exeminer must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		☐ Yes 2 TNo		Alcan, etc.)	Spec	ack, White, etc. ify: white
Maryland < 1 2 13-0030 td 2 should be filed within 72 hours alt lith and Mental Hygiene. 27 is marked other then "natural", or treumatic event, the Mudical Exerti- treumatic event, the Mudical Exerti-	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	S Education grade completed) College (1-4or 5+)	(Give I	O NOT use retire	during most of worki d)	ing	16b. Kind of	Business/Industry
filed v Hygie other t	ပိ	17. Father's Name (First, Middle, L	ast)		infan	18. Mother's Name	(First, Middle,	Maiden Suma	infant ame)
Ore, Maryland ZIZI les 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other then " or other treumatic event, the Max	To Be	Jason Micheal T		19b. Mailin	a Address (Street	Kimber	ly Ann		71797
		Kimberly A. Ti				Rd. Fernd			
SAILIMORE, bermit. Pages 1 ar Department of Hea mportent: If item: nn jinjury or other one.		20a. Method of Disposition 1	3 □Removal from State	20b. Place of Dispos cemetery, crem	ition (Name of atory or other pla		Date	20c. Location	- City or Town, State
Baltimor permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service L				ess of Facility St. timore St			
Physician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Extreme a.	Premat	urity	Rupture			Approximate Interval Between Onset and Death
						-			
d / OU, cate be executed physician and the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of).					
(U. BOX 68/6U, the death certificate be executed y the attending physician and ched for use as the burial-transit	ω	Cause (Disease or injury that initiated events	c	onsequence of): onsequence of): oregnancy □ Fetel death 3 □	Ectopic pregnanc Other (specify) _	у			late of delivery Month Day Year
'dS, P.O. BOX 68/60, ulres that the death certificate be executed n signed by the attending physician and ild be detached for use as the burial-transit	by Physician/Medical E	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c	onsequence of): oregnancy Fetel death 3 e of death 5	Ectopic pregnanc Other (specify)		23e. Did to	obacco use con	•
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ITAI RECOIDS, P.O. BOX 68/60, bias. The law requires that the death certificate be executed entificate has been signed by the attending physician and entificate has been signed by the attending physician and entities.	Completed by Physician/Medical E	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner?	c	onsequence of): oregnancy Fetel death 3 e of death 5	Ectopic pregnanc Other (specify) _ derlying cause gi	ven in Part I. 26. Place of Death	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes 1 (Check only on	Nobacco use con /es 2 \(\text{No} \) No sy med?	ntribute to the cause of death? 3 □ Probably 4 ℃ Unknow Were autopsy findings availate prior to completion of cause death? 1 □ Yes ※ No
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ertification; To Be Completed by Physician/Medical E	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of the basis of examiner: On the basis of examiner: Summer of the condition of the basis of examiner: On the basis of exam	onsequence of): oregnancy Fetel death 3 e of death 5 ot resulting in the un 2 ER/Outpatient aar) 28b. Time of Injury At home, farm, strespecify) by knowledge, death amination and/or invitation.	Ectopic pregnanc Other (specify) derlying cause give 28c. Inju Wo 1 iet, factory, office occurred at the tiestigation, in my 29c. Licen: P17	26. Place of Deather: 26. Place of Deather: 4 \(\text{Nursing Ho} \) The strict of	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes 1 (Check only or me 5 Resid 28d. Describe he 28f. Location (S City or Tow and due to the ored at the time, or	obacco use con 'es 2 \(\text{No} \) an 24b symed? All No ne) lence 6 \(\text{OO} \) con injury occu cause(s) and n date and place 29d. Date sign OCt. 1	Annual Route Number, and due to the cause(s)

	en Urqul	nar	Please 1	ype or Print in Black	k Inde	lible lnk. Ensure A	All Copies	Are Legible.		
-06 N	5729			State of Maryland / D				_		
TA			For State Registrar	•	•	icate of Death	- 1	Reg. No 2004	35030	
	۰		1. Decedent's Name (First, Middle, Last				2. Date of Dea Month	ath	3. Time of Death	
	Physici /Medic		Warren Allen Ur	quhart Jr.				Day Year 2004	2051 P ^M	
	Examin		4a. Facility Name (If not institution, give		41	c. City, Town, or Location of Deat	th	4c. County of Dea	th	
			Prince George's H			Cheverly		Prince G		
È	Funeral Director		212 27 4444 2	TM 005		Under 1 Year If Under 24 Hrs onths Days Hours Min.		r, Year) Co	thplace (State or Foreign puntry) yland	
	land W		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	n or Locati	on			10d. Inside City Limits	
	within 72 hours after death with the Maryland nne. than "natural", or liems 23s or 28s-1 show he Medical Examination and the collination	tor	Maryland Prince G	eorges Bowi	e				i¥∏Yes 2 ☐ No	
	r 28a	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	ountry?	
	th with	alD	13330 11th Stree	t		20715		USA		
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit		
36	or It		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		Yes 2 No Specify:		Specify:	e e e	
Ö	tural'	q pa	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	Decadent	's Usual Occupation		Afri 16b. Kind of Business	can-American	
5	in 72 n na n lie	olet	(Specify only highest grad	e completed)	(Give kind	d of work done during most of wo NOT use retired)	rking	Tob. Kind of Business	madstry	
21215-0036	Jiene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	lumb ϵ	er/Mechanic		Private		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examination and page.	To Be C	17. Father's Name (First, Middle, Last) Warren Allen Urqu	me (First, Middle, McGinnis	Maiden Sumame)					
ary	shou ind M imar umati	-	19a. Informant's Name/Relationship (T)	ural Route Numbe	oute Number, City or Town, State, Zip Code)					
	and 2		Lefa McCoy - Moth	MD 21830						
Baltimore,	ages 1 aent of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	20c. Location - City or						
Baltii	permit. I Departm Importal any inju		21. Signature of Funeral Service Licens Myselin T. VI							
			23a. Part1. Enter the disease, or compl						20722 Approximate	
	Physician :		shock, or heart failure. List only o Immediate Cause (Final disease or condition	Atheroscleratic		diovascular o			Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of						
	bed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):				-	
30,	oe executed cian and urial-transit	_	that initiated events resulting in death) Last	Due to (or as a consequence of	of):					
6876	ficate be physicial s the bu	dlca		d						
Box	ath certil ttending or use a	Physician/Medlca	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death		topic pregnancy her (specify)		23d. Date of del Month	ivery Day Year	
P.0	that the de led by the a detached f	hys	9 Unknown	9□ Unknown						
	quires tha n signed I uld be det	by	Part II. Other significant conditions co	bacco use contribute to es 2 □ No 3 □ Pr	the cause of death?					
I Records,		autopsy prior death							itopsy findings available completion of cause of	
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	1 - No.			ath (Check only or	76)		
of	S S ID	2	1 🔀 Yes 2 🗆 No	lospital: 1 ☐ Inpatient 2 ☐ €R/Out		The second secon		ence 6 Other (Spec	cify)	
ion o	ing	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Time of njury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred		
Division	tal or Attend s after death al Director: A ed in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street,	factory, office	28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Directory completely filled in by	edical (29a. Certifier 1 ☐ Certifying Phy (Check only one)	ner: On the best of my knowledge ner: On the basis of examination and and manner stated.	, death oc d/or invest	curred at the time, date and place igation, in my opinion, death occu	e, and due to the curred at the time, o	ause(s) and manner as late and place, and due	stated. to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier			29c. License number	2	9d. Date signed (Monti	n, Day, Year)	
			29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo October 18							



Registrar

31. Date filed (Month, Day, Year)

OCT 2 1 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 . Registrar's Signature

			1 - For State Registrar		State	of Maryl	and / Depa <i>Cei</i>	artment of <i>rtificate o</i>	Health f Deat	n and M h	lental Hyg	ienę	004	350	140
			Decedent's Name (First, Middle, L	ast)						2. Date of Deat	h		3. Time o	
	Physicia		Mary Wal	tha11							Month October	Day	2004	8:40	A M
	/Medic Examin		4a. Facility Name (If n	ot institution, g	ve street and n	u <i>mber</i>)		4b. City, Town	, or Locatio				County of Dee		
			1015 Neal	Drive				Rockvi	11e			Mor	ntgome	rv	
	Funeral		5. Social Security Num	nber 6.	Sex	7. Age (In)	rs. last birthday)	If Under 1 Ye		er 24 Hrs.	8. Date of Birth (Month, Day,		9. Bir	thplace (State	or Foreign
	Director		234-40-809	97	1 □ M 2 🗓 F		76 Yrs.	Months Day	/s Hours	s Min.	04/17/1	928		ou <i>ntry)</i> st Virg	inia
	D		Usual Residence of D 10a. State 1			10.	0: -								
	aryla shov	_		0b. County			City, Town or Lo							10d. Inside C	ity Limits 2 □ No
	Ba-f	Director		Montgom	ery	K	ockville							J	2 110
	with t	Ö	10e. Street and Numb					10f. Zip Code			110		en of What Co	ountry?	
	s 23	Funerai	1015 Neal	Drive	12 Was De	cedent Ever i	11.0	208		Origina (Co.	ait Van an Na		S A .	rissa ladisa	
	Herring.	-un-	 Marital Status Never Married 	2 N Married	Armed F	orces?	13.	f Yes, specify C	uban, Mexic	can, Puerto	cify Yes or No- Rican, etc.)	'	Black, Whit		
21215-0036	72 hours after death with the Maryland neturel', or ttems 23e or 28a-f show deal Examitter must be notified at	by F	3 ☐ Widowed 4		If Yes, G	live		I□Yes 2🛛 N	lo <i>Speci</i>	fy:		5	Specify: W	nite	
ŏ	2 hou			5. Decedent's I				lent's Usual Occ] .	16b. Kind	d of Business	/industry	
215	hin 7.	pie	(Specify Elementary/Second		rade completed	(1-4or 5+)	(Give	kind of work dor DO NOT use ret	ne during m ired)	ost of worki	ng			,	
21	e filed within al Hygiene. I other then ' vent, Ire Ma	Completed	2.0	(0 12)	5+	(1-40, 51,	Teach	er				Εdι	ıcation	n	
g	al Hy I other	Be (17. Father's Name (Fi		t)				18. Mo	ther's Name	(First, Middle, M	faiden S	lumame)	-	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23e or 28a-1 show other treumetic event. The Medical Examiner must be notified at	To	Bullis S	mith					Ir	ene F	isher				
lan	2 sho and Is my		19a. Informant's Nam	e/Relationship	(Type, Print)						l Route Number,			, ,	
	and ealth n 27		Earl Walt		lusband				rive,	Rockv	ville, Ma	aryl	and 20	850	
ore	of H of H if iter		20a. Method of Dispos 1 ☐ Burial 2 💢		□Removal from	State		natory or other p	, i				ation - City or		
Ĕ	Pag ment ent:		`4 □Donation 5			F	t. Linco	oln Crem	natory	10/1	9/2004 E	rent	twood,	Maryla	nd
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Fun	ral Service Lice	sch.	cels		. Name and Add		. 21	mple Tr			1and 20	852
			23a. Part1. Enter the shock, or heart f	disease, or contailure. List onl	nplications that	caused the d	eath. Do not ent	er the mode of d	lying, such a	as cardiac o	r respiratory arre	st,		Approxima Interval Bet	te tween
	Physician		Immediate Cause (Findisease or condition	nal	Meta	estatio	Breast	Cancer						Onset and 9 yea	Death
	/Medical Examiner		resulting in death)	-		(or as a con									
	LAGITITIE		Sequentially list condi	itions,	b										
	ed sit	iner	if any, leading to imm- cause. Enter Underly Cause (Disease or in)	ina 🚄	Due to	(or as a cons	sequence of):								
_	and and II-trar	Examin	that initiated events resulting in death) Las		c	o (or as a cons	sequence of):								
8760,	icate be executed physician and s the burial-transit	aiE				,	. ,								
687	ficate physics fisthe	edicai			d										
Box	death certifii e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, or							23	d. Date of del	iverv	
	death e atte d for	icia	in the past 12 mg	onths?	4☐Preg	birth 2□F nant at time (Ectopic pregnar Other (specify)				11 -	Month		Year
0		hys	9 Unknown		9□ Unk	nown									
s, P	requires that the een signed by th hould be detache	by P	Part II. Other significa	ant conditions	contributing to	death but not	resulting in the ur	derlying cause	given in Par	t I.	23e. Did tob	acco use	ontribute to	the cause of	death?
rds	w require been sig should b										1 ☐ Ye	s 2 💢	No 3□Pr	obably 4 🗆	Unknown
Record	~ D 0	Completed									24a. Was an		24b. Were au	topsy findings	available
	9 - 9	шо									autopsy	ed?	death?	completion of a 2 No	ause of
Vital	icien: Th certificate rector, pag	0	25. Was case referred	d to medical					26. Pla	ce of Death	(Check only one	No No	1 🗆 ; 63	20110	
	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 💢 No		Hospital: 1	Inpatient 2	ER/Outpatien	1 3□ DOA	Other: 4 🗆 I	Nursing Hon	ne 5 🔀 Resider	nce 6 [□Other (Spec	cify)	
1 0			27. Manner of Death	5 □ Banding	28a. Date	of Injury nth, Day Year	28b. Time of Injury	28c. In			8d. Describe how				
0	Attending ir death. ector: After by the fune	atic	2 Accident	5 Pending investigate	on	,,	, , , , , , ,		Yes 2	□No					
Division	or Attencater death after death Director:	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	1 28e. Plac	e of Injury - A	t home, farm, stre	et, factory, offic	е	2	81. Location (Str. City or Town,		Number or Ru	ıral Route Num	ber,
0	Hospital or 24 hours afte Funeral Dir tely filled in i			-											
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 (Check only 2 one)	Certifying P	hysicien: To the miner: On the and ma	e best of my basis of exam nner stated.	knowledge, death ination and/or inv	occurred at the estigation, in my	time, date a y opinion, de	and place, a eath occurre	nd due to the car d at the time, da	use(s) ar te and p	nd manner as lace, and due	stated. to the cause(s	;)
	To To COM	Σ	29b. Signature and titl	ertifier	1/	n			nse numbe	r			signed (Month		
)	<		10	1 Luga	111	negat,	YKA	D318	90		0	ctob	er 19,	2004	
	-		30. Name and address												
			Wayne Meye	er, MD,		edical Registrar's Si		Drive St	te 214	+, Roc	kville,	MD	20850		
	Sta Registr			20 20		Hegistrar's Si	Ly Ly	Sporks	1						
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DHMH 17 Rev 1/2001

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	RPD	, 02	1 - State Unpend Item Registrar	State of Mar. 23a, 27, 28	aryland/De∣ Ba-f peræ	ertmen Ertificati	t of H e of I	ealth a 33–04 3eath	and M tas	lental Hy	gien Reg. N	001		350	41
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)						2. Date of De Month	Da	ay y	(ear	3. Time of	
	/Medic	al	Earl W. Wyatt 4a. Facility Name (If not institution, give	etroot and number		4h Ciby	Tourn	Location	of Dooth	Octobe		1, 200		0512	A M
	Examin	er	Carroll Hospital			West			JI Death			Carro]			
3	Funeral Director		5. Social Security Number 6. S		e (In yrs. last birthda Q Yrs.	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay Year	956	9. Birthp Cour	lace (State of	r Foreign
7			Usual Residence of Decedent							0.011					
	72 hours after death with the Maryland naturel", or Itema 23a or 28a-f show Sical Examinar must be notified at	tor	MD Carro	11	10c. City, Town or Westn	Location ninste	er						1	0d. Inside Cit 1 ☐ Yes	
	ith the	Direc	10e. Street and Number			10f. Zip	Code				_	itizen of Wh	at Cour	ntry?	
	a 23a	ral	4320 Geeting		E		2115		-1-0 (0-			JSA	Amaria	on ladica	
	s after dea ', or Itema	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1	No			n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	0-		White,	etc.	
036	ours aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1976	1□ Yes	2 No	Specify:				Specify:	Whi	ite	
5-0	- × 30	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Gi	pedent's Usua we kind of wor . DO NOT us	rk done d	lurina mos	t of work	ing	16b. H	Kind of Busi	ness/In	dustry	
12	filed within Hygiene. Ither than "	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	elder	se remed	,			Co	onstr	uct	cion	
pu	at Hyg I other vent,	Be Completed	17. Father's Name (First, Middle, Last)							(First, Middle	, Maidei	n Sumame)			
ya	should but and Ment	^D	Everett Wyatt		405.14	W A 4 4	(0)			toner	. 01	- T - 0		0.41	
altimore, Maryland 21215-0036	s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 la marked other than other traumatic event, the M.	ì	19a. Informant's Name/Relationship (Sonja Wyatt	Type, Print)	432	20 Ge	etir	ng Ro	or or Hura	estmi	nst	er,MI	2 2 2	L158	
ore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dis	position (Nan rematory or o	ne of ther plas	em!		Date		ocation - C			147
ţ	Page 1		` 4 □ Donation 5 □ Other (Specific	()	John L									nster	
Bal	permit. I Departm Importat any inju		21. Signature of Funeral Service Licer	Loule	Q	22. Name an Littl	e's	FH .	у 34 М	lap1e	Ave	.Litt	:1e	stown	340 PA
			23a. Part1. Enter the disease, of com shock, or heart failure. List only	olications that caused one cause on each fi	the death. Do not e							_		Approximate Interval Bety	ween
	Priysician	2 1	Immediate Cause (Final disease or condition resulting in death)	a Heroin	And Cocain	e Into	xica	tion						Onset and D	eath
1	/Medical Examiner		Tosoning in doziny	Due to (or as	a consequence of):										
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760,				d											
9289	rtificati ng phy as the	Medic	IF FEMALE:	. 0.											
Вох	leath certifica attending pt I for use as tl	lan/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B Ectopic pr						23d. Date of		•	'ear
P.O.	The law requires that the death certificate be tte has been signed by the attending physicis bage 2 should be detached for use as the bu	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	tilme or death :	5 ☐ Other (sp	өспу)								
	es that igned b	by P	Part II. Other significant conditions of	ontributing to death b	out not resulting in the	underlying c	ause give	en in Part I		23e. Did	tobacco			ne cause of de	
ord	w require been si should I	eted									Yes 2			ably 4 □U	
Vital Records,	The law cate has b page 2 s	Completed									psy ormed?	prid dea	or to cou ath?	psy findings a npletion of ca	inse of
tal		Be Co	25. Was case referred to medical					26. Place	of Death	1 X Yes	-	0 1 _	Yes	2□ No	
of Vi	hyaician: this certific al director,	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatio			_	4 🗆 NU	rsing Ho	me 5 Res	idence	6 Other	(Specif	1)	
ou c	ing F	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Found Page 1	y Year) 28b. Time Found	of 2	8c. Injun Work	rat ⊲? Yes 2.⊊		28d. Describe	how inju	ary occurred			
Division	Attend	ifica	2 Accident Investigation 3 Suicide 6 Could not be determined	10-31-2	004 4:25 ury - At home, farm, c. (Specify)	A		X		Unkown 28f. Location (City or To	Street a	nd Number	or Rura	l Route Numb	ber.
Ö	ital or rs afte al Dir	Cert	4 - Hollicide	Scene	с. (Бреспу)				te	own Pik	e, We	es tm in	ste	ock Li	tties
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exar	ysician: To the best niner: On the basis of and manner st	f examination and/or	ath occurred investigation.	at the tim , in my or	e, date an pinion, dea	nd place, a th occurr	and due to the ed at the time,	cause(s date an	s) and mann d place, and	er as st d due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and marrier of	4104	290	. License	number			29d. Da	ate signed (Month,	Day, Year)	
3			+ Hamele + Sour	thall, mi)	0	.C.M	.E.			Oct	ober :	31,	2004	
			30. Name and address of person who Pamela E. Sa	completed cause of a			enn	Stree	et, B	altimo	re,	Maryl	and	21201	
	Sta Registi		31. Date filed (Month Ov. 194 2		rar's Signature		out		-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** WARFIELD GIRL 0640 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNRS HEALTHCARE BALTIMOR If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 KF Months Days Hours Yrs. Director N Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov treumatic event, the Medical Examiner must be notified at 1XYes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene.

Is marked other than "natural", or Items 23a or? 21212 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry, Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be mes 2 HODEWRI MO 19b. Mailing Address (Street and Number or Rural Route Number, City or 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ent: If Item 27 Is: EVESHA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MAY 6,2005 BALTIMORE, MD permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ST AGNES HEACTHCARE 21. Signature of Funeral Service Licensee Ili Advantong 900 CATON AVE BALTIMIRE, MD. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** membrand Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed COM n Due to (or as a consequence of): Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 🗌 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Cneck only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification; To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 🗌 Yes 2 No ☐ Accident Director: 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours e To the Funerel C 11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21229 MARC 900 CATON AVE E STEGEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

04

WARFIELD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) NOV 0 5 2004 3 Registrar's Signature

			For State Registrar	State of I	Maryland	Depa / Depa	rtment of He	ealth and <i>Death</i>	Mental Hyg	ier 2 e (104	350	44
Ī	Physici	an	1. Decedent's Name (First, Middle,			1.			2. Date of Deat Month	Day	Year	3. Time of	Death
	/Medic		EDMUND	ADAM		K	1		November	3,	2004	1:57	Α ^M
	Examin	ner	4a. Facility Name (If not institution, Franklin Square	Hospital	Center	1	Rosedal	e		Ba	unty of Death ltimor		
	Funeral Director		195–12–9510	5. Sex 1 X M 2 □ F	Age (In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			9. Birth Con PA.	nplace (State of untry)	Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside Cit	y Limits
	Mary -1 sh	tor	MD Balt:	imore		Dund	alk					1 🗀 Yes	
	or 288	lrec	10e. Street and Number				10f. Zip Code		10	g. Citizer	of What Co	untry?	
	death with the Maryland ms 23e or 28a-f show reast be rediffed at	ral	902 Forwood Cou	ct			21	222		U	SA		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28a-1 show amportent: If item 27 is marked other than "naturel", or items 23e or 28a-1 show amplified any injury or other treumatic event, the Medical Esaminer must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2X Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceded Armed Force of 1 X Yes 2 If Yes, Give Year or Date	es? □ No	If	as Decedent of His Yes, specify Cuban □ Yes 2 ∑ No	panic Origin? (, Mexican, Pue Specify:	Specify Yes or No- irto Rican, etc.)		Race - Amer Black, White ecity: W		
21215-0036	hin 72 ho e. an "natur Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4)		(Give k	ent's Usual Occupat ind of work done du O NOT use retired)	ion uring most of we	orking	6b. Kind	of Business/I	ndustry	
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-	nd 2 sho alth and I 27 Is me or troums		19a. Informant's Name/Relationship		rife				Rural Route Number, Dundalk, MD			ip Code)	
saitimore,	ages 1 a ent of Hea nt: If item y or othe		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 ↑ 4 □ Donation 5 □ Other (Spa	☐Removal from Sta	20b. Place ceme Carde	e of Dispos etery, crema ns of 1	ition (Name of atory or other place, Paith Cerrete		/ember		ion-City or T		
Baltil	permit. F Departme Importer any injur		21. Signature of Funeral Service Li		000) 22. C	Name and Address	of Facility Funer	al Home	Of 1	Dunda	lk,P.A	24222
			23a. Part . Enter the disease, or conshock, or heart failure. East or	omplications that cause	sed the death. [Oint Roa		Dunda	Approximate	
	Physician		Immediate Cause (Final disease or condition	4	MUN							Interval Betw Onset and D	
	/Medical Examiner		resulting in death)		as a consequent		Fusio						
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۱\ ۱ (۵۵/۵	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	0.	as a consequen								
٥		Medi	IS SEALLS										
O. BOX	w requires that the death certify been signed by the attending should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	ath 3 □E	ectopic pregnancy Other (specify)			23d.	Date of deliv Month		ear
as, r.	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant condition	s contributing to deat	h but not resultin	g in the und	derlying cause giver	in Part I.		acco use o		he cause of de	
Records,	ata a 2	Completed							24a. Was an autopsy perform		tb. Were auto prior to co death?	opsy findings a empletion of ca	vailable use of
		0	25. Was case referred to medical				,	DE Place of De		2No	1 🗆 Yes	2□ No	
>	ysicia is cer direct	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 ER/	Outpatient			Home 5 Residen		Other (Speci	fv)	
000	ding Physician: h. After this certific funeral director,	tlon: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigal		njury 28l Day Year)	b. Time of Injury	28c. Injury a Work?	ıt	28d. Describe how	v injury oc	curred	,,	
DIVISION	I or Atten after deal Director: I in by the	Certification:	2 Accident Investigal 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of	Injury - At home etc. (Specify)	, farm, stree			28f. Location (Stre City or Town,	et and Ni State)	umber or Run	al Route Numb	er,
	To the Hospitel or Attending Physicien: which 24 hours after deals are deals the Funesel Director. After this certifica completely filled in by the funeral director; to	edical C	29a. Certifier Check only one) Certifying 2 Medical Ex	Physician: To the be aminer: On the basis and manner	st of my knowled s of examination stated.	dge, death of and/or inve	occurred at the time stigation, in my opir	, date and plac nion, death occ	e, and due to the cau urred at the time, dat	use(s) and e and pla	manner as s	stated, the cause(s)	
	To the vithin To the comple	Me	29b Signature and Hills of certifier		MN		29c. License	number	29	d. Date si	gned/(Month,	Day, Year)	
			The contraction of the contracti	-8	/		071	076		15	109		
	10		29b Signature and this certifier 30 Name and address of person with the service of the	A 530	death (Item 23	a) (Types P	106 PIts	LAUFU	obi And	, Bn	47MO	NE, 21	237
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5	2004 32. Reg	strar's Signature	B	Spark	1					

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Maryland		artment of H tificate of L		Reg	2004	35045
	Physicia		Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
13.	/Medic	al -	Gail Clinton Arno 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	TOCIV	4c. County of Death	11 307
	Examin	er	Mariner Health of			Catonsvi	lle		Baltimore	
	Funeral		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,)	(eer) 9. Birthpl	ace (State or Foreign try)
t	Director		213-36-3340 Usual Residence of Decedent	64	Yrs.			Sep. 19,	1940 Tenne	ssee
	yland		10a. State 10b. County	10c. City	y, Town or Lo	cation			10	Od. Inside City Limits
	e-fst	ctor	PA Berks	Hamb	urg					1 ☐ Yes 24QXNo
	or 28	Dire	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Coun	try?
	e 23e	ar a	506 Overview Driv	7e 12. Was Decedent Ever in U.	S 13	19526	ispanic Origin? (Sc	ecify Yes or No-	USA 14. Race - America	an Indian.
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Proportent: If item 27 is marked other then "naturel", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examinar most be notified at once.	by Fur	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2⊠ No			Black, White, e	etc.
ည်	be filed within 72 hours a ral Hygiene. d other then "naturel", o event, the Medical Exam	Completed	15. Decedent's Edu (Specify only highest grad	ication (e completed)	(Give	dent's Usual Occupa	during most of work	sing 16	6b. Kind of Business/Ind	lustry
21215-0036	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Salesi	DO NOT use retired	()		Public sale	e
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a	lid be fental fked c	To Be	Clinton Arnold				Mary Wa	lker		
ary	and N is mar		19a. Informant's Name/Relationship (T	ype, Print)	1				City or Town, State, Zip	
Z,	and and sealth m 27		Randy Arnold- son	20h B	506 (byerview]	Drive, Ha	mburg. P.	A 19526 Oc. Location - City or To	State
Baltimore, Maryland	Pages 1 ment of H ent: if ite lury or of		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Removal from State Bal	Loudo	Temator Park	Nov.3	3, 2004 Ba	altimore, M	aryland
Ball	Depart Import ony in		21. Signatury of Funeral Service Access	Campu	130	520 Wilker	ns Ave	Baltimore	Funeral Ho e, Maryland	me 21229
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deeth ne cause on each line.	h. Do not en	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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	/Medical Examiner		f	Due to (or as a consequ	uence of):					
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68760,	icate be executed physicien and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequent	uence of):					
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.O. Box	ne death certif the attending thed for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3[Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
Ω.	law requires thet the dias been signed by the 2 should be detached	by Ph	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
rds	v requires I been signe should be							1 🗌 Yes	2 □ No 3 □ Prob	ably 4 Hiknown
Records,	0 5 0	Completed						24a. Was an autopsy perform	ed? prior to con death?	osy findings available inpletion of cause of
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	Linning.		04		th (Check only one)	
of	w =	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie		Nursing H	ome 5 Residen 28d. Describe hov	ice 6 Other (Specify	")
uo	After After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 2000. 2010.	wijary occarroc	
Division	if or Attending after death. I Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)		reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura. Stete)	l Route Number,
	Hospita 4 hours Funeral taly filled	Medical C		ysician: To the best of my kno liner: On the basis of examina and manner stated.						
	To the within 2 To the complex	Me	29b. Signature and title of certifier	100	,	29c. Licens	e number	29	d. Date signed (Month,	Dey, Year)
)			Jasuem	Yalliam		Do	727 17		11 304	
	\		30 Name and address of person who of	completed cause of death (Item	n 23a) (Type	Print) PAR	ie HEIG	Contro F	HIE BAR	(IMO)
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	dature	South				4201

State of Maryland / Department of Health and Mental Hygiene 2004 35046 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:35 Pm. M Donald Anderson Oct 27, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Maryland General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Yrs Md. Aug 18, 1957 213-70-5185 47 Director Usual Residence of Deceden permit. Pages t and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or Itame 23= ~- ~ any injury or other traumatic event. The page 2000. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐¥es 2 ☐ No **Baltimore** N/A Completed by Funeral Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 2303 Ruskin Ave 21217 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces' 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Black 3 Widowed 4 Devorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working UNL life. DO NOT use retired) 16b. Kind of Business/Industry University Hospital Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Barbara Jackson Alfred Jackson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1506 Pennsylvania Ave. Apt #7 Baltimore, Maryland 21217 Robin Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/03/04 Landsdown, Maryland Mt Zion 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Estep Brothers Funeral Home P.A 1300 Eutaw Place Baltimore, MD 21217 Tiles 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) umon **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Day Year Month jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 No detached Ö ed by the 9 Unknown 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I À Records. 9 sign 2 🗆 No 3 Probably 4 Mhknown 1 Yes Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has page 2 2 No certificate 1 ☐ Yes of Vital after death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 2 ER/Outpatient 3 DOA Certification: To ate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death of or Attending Fatter death. Division 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide Hospital 24 hours a Pruneral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Lo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 D 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State NOV 0 5 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35047 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Day Year **Physician** BARNES 10:50 A M LILLIAN 272 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOURS HOSPITA1 BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1 M 2 M 214-62-688 SDYrs. Director MD -16-1954 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b Count 10a State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinator must be invitilled at MD BALTIMORE 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 3314 Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 100 No f Yes, Give Year or Dates: 1 Never Married 25 Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTAN HEALTHCARE 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Pages 1 and 2 should be HARRY Is markad GRAY DLIVIA BROWN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAUDE J. GRAY f Heelth 1712 LAKESIDE AVENUE NOC BALTIMORE, MD21218 othar i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 20 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 11.08.04 ZION 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAURHNC. 21. Signature of Funeral Service License REFUNERAL SERVICES NATIL PIKE BALTIMURE, MD 2122 Wangh 23a. Part I. E teathe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last physiclan and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 2No Certification: To patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A investigation 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 300 ARMORY BHAKAK 2. Registrar's Signatur 31. Date Wed (Month, Day, Year) State NOV 0 5 2004 Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records.

		For State Registrar	State of Ma	aryland / [Depa <i>Cer</i>	rtment of H tificate of L	ealth a Death			Reg. No	1 1 1 4 44	3	35048
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La Do ROTH Y 4a. Facility Name (If not institution, gi	BL	IRTON		4b. City, Town, or	Location of		Date of Dea	Day O	4	w4	3. Time of Death
Funeral Director			Sex 7. Age	TIMOK a (In yrs. last bir 59	thday). Yrs.	If Under 1 Year Months Days	MORE If Under 2 Hours	Min.	Date of Birt (Month, Da	th y, Year)	9.		ce (State or Foreign
Maryland	tor	Usual Residence of Decedent		10c. City, Tow Balti									Inside City Limits
ath with the 23a or 28i	ral Director	10e. Street and Number 3700 Chestnut Ave				10f. Zip Code		211			zen of What		is.
1036 ours efter de ral', or Items Examiner in	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ⚠️ Pivorced	12. Was Decedent I Armed Forces? 1 Yes XXI I I Yes, Give Year or Dates:			Vas Decedent of His Yes, specify Cubar Yes 2KXNo	spanic Orig n, Mexican, Specify:	in? (Specit Puerto Río	fy Yes or No- can, etc.)		14. Race - A Black, V Specify:	/hite, etc	
Maryland 21215-0036 d 2 should be filed within 72 hours effer death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12) 12	ade completed) College (1-4or 5	+)	(Give	ent's Usual Occupa kind of work done d 00 NOT use retired) SS Office	luring most)			Ali	nd of Busine ce Mai sing (or	stry
aryland should be filk and Mental Hy a marked oth umatic event	To Be	17. Father's Name (First, Middle, Las Thomas William Do	odson, Sr.	10	Marin-		Cat	herir	First, Middle, ne Jean	nnet	te		
NG 2 of 18 o		Ronald W. Coleman 20a. Method of Disposition		37	00	g Address (Street a Chestnut sition (Name of latory or other place	Avenu		altimo	re,		211	
Baltimore, permit. Pages 1 at Department of Hee Important: If Item any injury or other		1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Fineral Service Use	(b)	Crest	La Car	wn Memori lens lame and Address Talls	a1	11/4/	04	Mar	riotts	svil	le, MD
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death certificate be executed Examinated and search of or use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1. Season of the cause of the ca	b. Due to (or as a	a consequence	of):								
the death certifical by the attending phytached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Xho 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				2	3d. Date of Month	delivery Da	ıy Year
Hecords, P. The law requires that ste has been signed b sage 2 should be deta	by	Part II. Other significant conditions	contributing to death bu	at not resulting in	the un	derlying cause give	n in Part I.			bacco u		e to the o	cause of death?
	Completed								24a. Was a autop: perfor 1 Yes	sv	prior death	to compl	findings available etion of cause of
Or VITAL F Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital:	nt 2 X ÉR/Ou	tpatient	3□ DOA Othe			Check only or 5 🗌 Resid		Other (S	pecify)	10
DIVISION OT or Attending Phy after death, Director: After this I in by the funeral d	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be			Time of njury	28c. Injury Work' M 1 \(\triangle Y		280	I. Describe h				
DIVISIC Hospital or Attand !4 hours after death Funeral Director: tely filled in by the f		4 Homicide determined	building, etc	. (Specify)					Location (S City or Town	n, State)			
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and	d/or inv	estigation, in my opi	inion, death	occurred	at the time, d	late and	place, and c	lue to the	e cause(s)
Mitty To COT	2	29b. Signature and title of certifier	Kin			29c. License	number	2 (2	29d. Date	signed (Mo	onth, Day	(, Year)
c'		30. Name and address of person who	completed cause of de	ath (Item 23a) (29c. License D G Print) HOSP17 Sports	TAL	OF	BALTI	יאוני	RE	-01	T
Sta Registra		31. Date filed (Month, Day Year) 20	04 32. Fegistra	r's Signature	4	Sparks	/		,				

J			1- For Unpend Item 23a,27,28a r per me	actesent pt ertificate of	Health and I Death	Mental Hygid	2004	35049
	Physici /Medi		1. Decedent's Name (First, Middle, Last) DAVID E. BURY			2. Date of Death Month NOVEMBER	Day Year	3. Time of Death 5:46P. M
	Examir		4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL	ROSEDAI			4c. County of Death BALTIMORE	
3	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 12 18 - 36 - 5396 15 M 2 F 63 Yrs.	Months Days		8. Date of Birth (Month, Day,) 6/26/	year) 9. Birth Cou	place (State or Foreign htry) LAND
	within 72 hours after death with the Maryland ane. than "netural", or items 23e or 28a-1 show te Mudical Everilier must be notilised at	Funeral Director	10a. State 10b. County 10c. City, Town or L MD BALTIMORE 10e. Street and Number	ROSEDAL	E	100	g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with 23e or ust be	ralDi	1112 ROSEDALE AVE.	2123	37		USA	,
920	ours after death with	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerton Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White Specify: WI	
21215-0036	s 1 and 2 should be filed within 72 hours I Health and Mental Hygiene. Item 27 Is marked other than "netural; other treumatic event, the Musical Exe	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occu e kind of work done DO NOT use retire CHINIST	during most of work	king	Sb. Kind of Business/Ir	RK & SEAL
pue	be filed ntal Hygie ed other event,	Be	17. Father's Name (First, Middle, Last) DAVID JOSEPH BURY			ne (First, Middle, Ma	viden Sumame)	
Maryland	2 should be to and Mental I is marked or reumatic eve	2		ling Address (Stree			City or Town, State, Zij	Code)
	of Health are item 27 is		20a. Method of Disposition 20b. Place of Disp	2 ROSEDA cosition (Name of ematory or other pla			ORE MD.	
altimore,	permit. Pages 'Department of H Importent: If ite any injury or ot		'4 □ Donation 5 □ Other (Specify) BAYVIEW	CREMATO	ORY 11/5		ALTIMORE,	MD
Ba	Depa Impo any in				VŠKI TUN NDALK AV		ME P.A. IMORE. MI	21222
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alcohol and Meper Due to (or as a consequence of):	iter the mode of dy	ing, such as cardiac	or respiratory arrest	ι,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause in the first of the carry of the cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):					
P.O. Box 6	Attending Physicien: The law requires that the death certifical cleath. crossin. sctor: After this certificate has been signed by the attending phy the tuneral director, page 2 should be detached for use as the	Physician/Medical		□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause gr	ven in Part I.		cco use contribute to the	ne cause of death?
Division of Vital Records,	icien: The law re certificate has be rector, page 2 sho	Completed	Of Was are placed to make			24a. Was an autopsy performed	d? prior to co	psy findings available mpletion of cause of
fVit	Physicie this certi al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3□ DOA Ott		h Check onlone me 5 Residenc	e 6 Other (Specific	v)
sion o	To the Hospital or Attending Physicien: The within 24 buss after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 YSuicide 6 Could not be	P ^M 1□	ryat rk?]Yes 2. ∰TNo	meperidin		
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certifi	determined 288. Place of injury - At nome, farm, st building, etc. (Specify) Residence			cosedale, E	Saltimore (
	the Hospital hin 24 hours a the Funeral upletely filled	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the till evestigation, in my o	me, date and place, opinion, death occur	and due to the caus red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the To the Company	Σ	29b. Signature and title of centrier	29c. Licens			Date signed (Month,	
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	.M.E.		VEMBER 3,	
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature	111 Penn	Street,	Baltimore	, Maryland	21201
	Registr		NOV 0 5 2004	de				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Michael Buda 9:30 A. M October 28 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 216 09 9650 86 26, Mary Land Director 1917 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State in than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1118 Armistead Street 21061 U.S. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If item 21 is marked other transfer any injury or other traumatic event, Ita once. Surveyor 12th City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Budahazy Maria Stepka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Etheridge / Niece 5810 Larsen Street Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 10/30/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee manueae 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEDMONIA Physician ASPIRATION /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 I ER/Outpatient 3 DOA 1 Yes 2 No ဥ 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 21776 OCTOBER 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE SULVED 1. MUNDRA MU ST S-HANDUER 3001 My 21220 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2004 Registrar

			State of Maryland / Department of Health and Mental Hygien 1- For State Registrar Certificate of Death Reg. N	2004 3505	ı
	Physic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Discount of the Company of the	Day Yeer 3. Time of Death	
	/Medi Examir			4c. County of Death	
	Funeral Director		5. Social Security Number 215-10-6440 6. Sex 1	O. Dietaria - /Chata as Cas	eign
	/aryland show	ŏ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Lim 1 ☐ Yes 2)X	
	with the N a or 28a-	Directo	MD Harford Darlington 10e. Street and Number 10f. Zip Code 10g. C	Citizen of What Country?	
3	Naryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or itams 23a or 28a-1 show raumatic event, the Medical Exeminations the notified at	y Funeral		14. Race - American Indian, Black, White, etc.	
L	Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. mportent: If itam 27 is marked other than "natural", or my inury or other traumatic event, tra Modical Exemple.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. If the contract of the contract of working life. DO NOT use retired life.	Kind of Business/Industry	
3	d 21 filed w Hygier ther th	Cor	4+ years Teacher Ele 77. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide, Maide)	ementary School	_
	irylan should be nd Mental marked o matic eve	To Be		and	
;	Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other traumatic		Susan Brand- Daughter 1836 Glenville Rd., Darlington, I 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition) Date 20c. L		
	Limo Page tment of tent: If		'4 Donation 5 Other (Specify) Darlington Cem. 11/05/04 Dar	lington, MD	
	Departing Departing any in		21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, 123 S. Washington, Havre de	Grace, MD 21078	
•	Physician /Medical		23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Approximate Interval Between Onset and Death I d (U)	~
100	8760, cate be executed monysician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):	0	
i	C 687	Medical	d.		
	Hecords, P.O. Box 61 The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year	
4	COrds, P. w requires that been signed b should be deta	b	Part II. Other significant continuous continuous to death but not resulting in the underlying cause given in Part I.	o use contribute to the cause of death? 2 No 3 Probably 4 Unknow	wn
rea.	DIVISION Of VITAL HECONDS, to Attanding Physicien: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed	24a. Was an autopsy performed?	24b. Were autopsy findings availate prior to completion of cause of death? Description 1 Description Yes 2 Description No	ole of
主	VITA VITA icien: certific rector,	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)		_
Brand, Dorothea	VISION Of VITAI Attanding Physicien: r death. ector: Atter this certifica y the funeral director, p	tion; To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Hesidence		-
and	DIVISIO	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street as building, etc. (Specify)	and Number or Rural Route Number, te)	
B	UIVISION OI To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s of check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.	s) and manner as stated. Id place, and due to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier D32 609 11	ate signed (Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamme on Military MD 1106 Revalution it Hame be brown	LE MD21078	
	Sta Registi		MONE A CORP.		

State of Maryland / Department of Health and Mental Hygien 00 1 35052 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 13:20 PM /Medical 1 homas 3 November 200 H 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Me 5. Social Security Number Baltimore
If Under 1 Year If Under 24 Hrs. Hospita Memorial 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Hours Yrs. Director 214-40-0483 02-28-1944 MD Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits item 27 is marked other than "neturel", or items 23e or 28e-f show other treumatic event, the Mcddal Experience must be notified at 1 ⊈Yes 2 □ No Director NIA Baltimore MD 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2836 death by Funeral Avenue 21213 U.S.A. 12.)Was Decadent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) iiit. Pages 1 and 2 should be filed within ortment of Health and Mental Hygiene. ortent: If item 27 Is marked other than njury or other treumatic event, the Market of the program of the present of the Market or other tre Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Baher 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore Streams Ward atherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2836 Kentycky Sadie M. Boyd Wife Baltime M 712 Ave. MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro rematory 11.09-04 Catonsville MD permit.
Deportrainments
any nju 21. Signature of Fun rai Service Lansee 22. Name and Address of Pacility Howell Funeral Home 23a. Part1. Emar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Ser Physician Sis disease or condition resulting in death) 3 weeks /Medical Due to (or as consequence of): Examiner SRD 2 mon lins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uterace of higher that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed 20 the burial-tran leaus resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 years Physician/Medical Diabele use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 46 autopsy performed? 1 Yes 2 110 Hospitel or Attending Physicien: 24 hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) our Vella Lay howar AT 2438 November 3rd 2004 201, EAST UNIVERSITY PARKWAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOWRL, VEERARAGHAVAN 21218 BALTIMORE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department State of Maryland / Department Certification	nt of Health and Mental Hyte of Death	ygiene 2004 35053
	Physici /Medio		1. Decedent's Name (First, Middle, Last) CVELUN M. BOSSALINA	2. Date of D	Day OCH 6 AM
	Examin		2 Kelbark Ct.	r, Town, or Location of Death PARKULL or 1 Year If Under 24 Hrs. 8. Date of B	4c. County of Death BALTI MORE Sith Para (State or Foreign
	Funeral Director		212-18-5884 1□M 2MF 87 Yrs. Months Usual Residence of Decedent	Days Hours Min. (Month, L	5-16 Pennsylvania
	ne Marylan 8a-f show	Director	10a. State 10b. County 10c. City, Town or Location PARK	VILLE	10d. Inside City Limits 1 Yes 2 No
	eath with the 23s or 2	Funeral Dire		ip Code 21234 selent of Hispanic Origin? (Specify Yes or N	10g. Citizen of What Country?
960	n 72 hours after death with the Maryland "neturel", or Items 23s or 28s-f show after Examirel must be neilified at			edent of Hispanic Origin? (Specify Yes or Nectly Cuban, Mexican, Puerto Rican, etc.) 2 No Specify:	Specify: White, etc.
21215-0036	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. Item 27 is marked other then "netu other traumatic event, It a Madical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Sepondary (0-12) College (1-4or 5+)	ork done during most of working use retired)	16b. Kind of Business/Industry
	2 should be filed and Mental Hygie is marked other aumatic event, ii	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle Margary Lt	
, Maryland	i and 2 should Health and Men Iem 27 is marke		192 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (AROLUN M. COACO daug. 2 Kolb	ss (Street and Number or Runal Route Num Ork Ct., Parkvi	lle MD 21234.
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	other place) 1. POLK. 11-6-04.	PARKVILLE, MO
Bal	Departi Departi Imports any inju		21. Signature of Funeral Service Licensee 22. Name a EVAN 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mo	FUNERAL HOME, 88	RCO HARFORD RO- arrest, Approximate
	Physician /Medical		shock, or heart failure. List only one/cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arterio Sclerufic Card Due to (or as a consequence of):		Interval Between poset and Death
	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying		
8760, -1	ate be executed hysician and the burial-transit	ai Examlner	Cause (Disease or injury that initiated events c		
9	ate hy:	v/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
.O. Box	that the death ted by the atter detached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23b. Was decedent pregnant in the past 12 months? 4 □ Pregnant at time of death 5 □ Other (state of the past 12 months)		Month Day Year
ords, P	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	by	Part II. Other significant contained to contributing to death but not resulting in the underlying	3	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Vital Records,		Completed		per 1 Yes	opsy prior to completion of cause of death? 28 No 1 Yes 2 No
f Vita	Physician: Th this certificate ral director, pag	To Be	examiner?	26. Place of Death (Check only OA Other: 4 Nursing Home 5 Res	
ion of	Ing After fune			28c. Injury at Work? 28d. Describe	how injury occurred
Division	tel or Attenders after deathel Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office 28f. Location City or To	(Street and Number or Rural Route Number, own, State)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) (Check o	n, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
)	Mith To 1	2		D-17041	29d. Date signed (Month, Day, Year) O3 November 2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marc I. LEAVEY MO 1205 YORK ROA	P #38 LUTHERUI	03 November 2004 LLE M9 21093
	Sta Registi		NOV 0 5 2004 Security Signature Spacks.		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 35054 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November3, **Physician** Stephen Bryan Bauer, Sr. 2004 4:45 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1952 Sue Creek Drive Essex Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 214-44-1923 59 Director 26,1945 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "naturel", or Items 23e or 28a-f ehow the Mudical Examiner count be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Funeral Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1952 Sue Creek Drive 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify 3 Widowed 4X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Boiler Maker Steel injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F Joseph Bauer ပ Alice McCollom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Depertment of Health and Important: If item 27 is n eny injury or other traun 697 Carrollwood Road, Baltimore, Maryland 21220 of Disposition (Name of Date 20c. Location City of Town, Stete Stephen Bauer, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Nov.6,2004 *4 □Donation 3 □ Other (Specify) Baltimore, Maryland ^{22. Name and Address of Facility} Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Euneral Service Licensee 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death yrs Immediate Cause (Final METASTATIC **Physician** ADENOCARCINOMA OF BLADOBR resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 10 the Funerel Director: After this certificate has been signed by is completely filled in by the funeral director, page 2 should be detact. 23e. Did tobacco use contribute to the cause of death? Part If, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 12 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 Yes I or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital or within 24 hours aft To the Funeral Di 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philopelphia Ro #314, Baltimice 21237 AUERBACH nichAE! 31. Date filed (Month, Day, Year) NOV 0 5 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Charles Edward Bell 26, 12:50 AM October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Stella Maris Hospice Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 12 M 2□ F Yrs **Director** Nov. 26,1920 Maryland 83 219-01-4778 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Dundalk Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21222 8169 Gray Haven Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 Yes 2 No Specify: Specify. 3 XWidowed 4 ☐ Divorced White "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Crown Cork & al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plater 9 Years Seal Corp. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental Find Men Ann Margaret John E. Bell P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Oakwood Road Dundalk, Maryland Margaret Zapf / Daughter Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Cemetery 11/1/2004 Sykesville, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature J For eral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the huria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9∏Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence Softher (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 29a. Certifier 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi

State Registrar

31. Date filed (Month, Day, Year) NOV 0 5 2004

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 Dulaney Valley Rd, Timonion MD 21093

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	/Medid		Margaret Ruth Bed						OCTOR	ER.	31,6		6:30P M
7	Examin	er	4a. Facility Name (If not institution, giv Saint Joseph		Center	4b. City,	Town, or Loc	ation of Death		4c.	County of		imore
	F		5. Social Security Number 6. S		(In yrs. last birthday)	If Under		Under 24 Hrs.	9 Date of Bir	th		9. Birtho	lace (State or Foreign
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	death	by Funeral	11. Marital Status	12. Was Decedent Ev	rer in U.S. 13.	Was Deced	lent of Hispa	nic Origin? (S	pecify Yes or No o Rican, etc.)	-			an Indian,
9	or ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give		1 ☐ Yes 2		nexican, Puen <i>pecify:</i>	o Hican, etc.)		Specify	Mhite,	etc.
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ylar	Menta Menta arked	ToE	Frank D. Magers					Margaret					
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 35058 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician Litopy /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Under 1 Year If Under 24 Hrs. Johns Hopkins Bayview Medical Center N/A Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 ☐ M 2√2 F Yrs. 53 **Director** 220-68-0342 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examinant must be nutified at 1 Yes 2 No Director Baltimore City Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States 153 North Elwood Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2√√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mentat Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 8 Years Homemaker Own Home or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked othen y injury or other treumatic event Lucy Pennington Leroy Adkins ပ 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bridgette A. Bishop 1709 Searles Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cem. 10/29/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. 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			1 - For State Registrar	State of M	aryland / Dep	artment of Fertificate of		•		1
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	Funeral Director		5. Social Security Number 6. S 243-50-0531	ex 7. Ag	e (In yrs. last birthday 68 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Day 12-18	h . 9.	Birthplace (State or Foreign Country) RTH CAROLINA
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Maryland 2	should be filed nd Mental Hygid I markad other umatic evant, II	To Be C	17. Father's Name (First, Middle, Last) CHARLIE BAZEMOR				18. Mother's Nam	ne (First, Middle, GILLIA)	Maiden Surname)	
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marks any injury or other traumatic once.		19a. Informant's Name/Relationship (DEBORAH JOHNSON 20a. Method of Disposition 1 ☑ Surial 2 ☐ Commation 3 ☐ 1 ☐ Donation 5 ☐ Othe (Specification 2) ☐ Commation 2 21. Signature ☐ ☐ ☐ ☐ Service ☐ ☐	(DAUGHTER) Removal from State	20b. Place of Disp cometery, cre KING MEMO	osition (Name of matory or other plac DRIAL PARK	A DRIVE A	PT 1C BADate -2004 OR H. WI	ALTIMORE, 20c. Location - City BALTIMOR	MARYLAND 2124 y or Town, State E, MARYLAND UNERAL HOME,
38760,	Physician /Medical Examiner the prival-transit	dical Examiner	23a. Part1. Enter the disease, or com shock, prieart failure. List only immediate Gause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as C.	the death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
O. Box 6	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
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ion of Vital	ng Phya fter this ineral dir	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. Injury Work	at Nursing Ho	me 5 🗆 Reside	e) ence 6 Other (S ow injury occurred	pecify)
Division	el or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farm, sti c. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Medical Exam	ysician: To the best of iner: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	h occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the cared at the time, da	ause(s) and manner ate and place, and c	as stated. due to the cause(s)
)	To To t	M	29b. Signature and title of certifier	Muc	and	29c. License			9d. Date signed (Mo	
	10			completed cause of de		Print)	NENTHE WOALS	JEJ Z	Her pita	29, 2004 4L CONTAR 4ND 21133
• 4	Sta Registr		31. Date filed (<i>Month, Day, Year</i>) NOV 0 5 2004	32. Registra	tr's Signature	park				

			1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygier	4004 35060
	Physici /Medio		1. Decedent's Name (First, Middle, Last) FLORA MAC	CAGER		2. Date of Death Month	2004 07-05 HWK
	Examir Funeral Director		5. Social Security Number 6. Sex 216 · 18 · 9808 101	The set and number) The set and number) 7. Age (In yrs. last birthda 80 Yrs.	4b. City, Town, or Location of Dea P	8. Date of Birth	4c. County of Death
	h the Maryland r 28a-f show	ō	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City, Town or	Location		10d. Inside City Limits 1 IXY es 2 □ No
	with the ha	Direct	10e. Street and Number 23 N. WHEEL		10f. Zip Code		Citizen of What Country?
5-0036	hours after death with the Maryland urel; or Items 23a or 28a-f show Il Extraiter in Mat be notified at	by Funeral Director			3. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:		14. Race - American Indian, Black, White, etc.
21215-0	n 72 n mat	Completed	15. Decedent's Educa (Specify only highest grade	completed) (Gir	bedent's Usual Occupation we kind of work done during most of wo be NOT use retired) HOMEMAKER	rking 16b.	Kind of Business/Industry DOMESTIC
Maryland 2	ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If item 27 is marked other than or other treumatic event, II.e M	To Be Co	17. Father's Name (First, Middle, Last) JAMES GRIE	R	18. Mother's Na	me (First, Middle, Maide	en Sumame)
	s 1 and 2 sho of Health and I item 27 is ma		19a. Informant's Name/Relationship (Type WILLIAM CAGCE	., SR. 881	8 MEADOW HE	IGHTS RI	v or Town, State, Zip Code) 21133 D. RANDALLSTONN, MD
Baltimore,	Pa nen ent: ury		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	GARR	ISON FOR STILL	9.04 on	Location - City or Town, State
Bal	permit. Departe Importe any inj		21. Signal are of Funeral Service License		22. Name and Address of Facility VAUCHN U. ELCENE 5151 BALTIMURE N	FUNERAL ATIONAL PI	Sel2/198 IKE BALTO MD 21/220
1	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	LUNG CAM	1000	Approximate Interval Between Onset and Death MowTHS
68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate clause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
.O. Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		E Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that the been signed by th should be detache		Part II. Other significant conditions contr	buting to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Onknown
of Vital Records,	The taw ate has b page 2 st	Completed				24a. Was an autopsy performed?	
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	spital: 1 Anpatient 2 ☐ ER/Outpati	Other	ath (Check only one)	6 Debat (Specific)
ion of	fter	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how inju	
Division	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, Sta	
	the Hosp hin 24 hou the Fune mpletely fil	Medical	one)	ien: To the best of my knowledge, dear: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	rred at the time, date ar	nd place, and due to the cause(s)
	Z wit	_	29b. Signature and title of certifier WHELCS	$M \cdot \delta$.	29c. License number		ate signed (Month, Day, Year) EMBEL 17004
\ =	H		30. Name and address of person who com WAN A CEASAL 21. Date filed (Afgath, Pay, Year)	821 N EUTAW	STREET STERC	18 BATIN	MORE MOZIZOI
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 20	32. Registrar's Signature	5 Sparks		

State of Maryland / Department of Health and Mental Hygiena 1 - For State Registrar 35061 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JAMES CORREL 5:00 P.M 2004 /Medical ctober 30 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b, City, Town, or Location of Death Munder 1 Year If Under 24 Hrs. Healt are 5. Social Security Number 242-14-0407 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Funeral Days Hours 1 XM 2 □ F 83 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventries must be notified at 10d. Inside City Limits BALTIMORE MD Director 1'Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 340 GWYNN AVENUE 2/229 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Styes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 Never Married 2 Married Specify: BUCK 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event. It a Med Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL 12th grade LABORED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM C. CORRELL ANNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 GWYNN AVENUE JANE CORRELL BALTO, MD 21229 NIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pal from State 1 > Burial 2 □ Cramation → □ Rer 4 □ Condition → □ Other (Specify) 21. Signal re of Fun al Service Licensee -∂-□Ren GARRISON FOREST 11.05.04 DWINGS MILLS, MD 22. Name and Address of Facility
VAUCHN C. GIZRENE FUNERAL SERVICES
5151 BAUTIMORE NATIONAL PIKE BAUTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aherscle votic Physician Cardwaleniar disease or condition resulting in death) YEGVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Physician/Medical JF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Gory Tunica 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Vital 2 No 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 ☑ No of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bunt October 30, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 Schuggs 900 Cuton Avenue Bultmere Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State WOLL OL 5 2004 Registrar

D	US		1- For Amend Item 1 Registrar	State of Marylan	ng1/_Beg	rtmagt of Hea	alth and Mo	ental Hygier	2004	35062
			Decedent's Name (First, Middle, Last)			incate of De		Reg. I 2. Date of Death		3. Time of Death
	Physic /Medi		Clettes C	ameron	Cur	tis		Month totober 23	Oay Year 3, 2004	0340a M
	Examir	ner	4a. Facility Name (If not institution, give s Shock Trauma	treet and number)		4b. City, Town, or Loc Baltimo			4c. County of Death	/^
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
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	yland low		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity Town or Lo	cation				10d. Inside City Limits
	e Man la-f sh	ctor	la N	IA X	Balti	MKe)				1 Pres 2 No
	with the	Director	10e. Street and Number	1	101	10f. Zip Code	7 ^	10g. (Citizen of What Cou	ntry?
	death ms 23	Funerai	11. Marital Status	2. Was Decedent Ever in (/S. 13. V	Vas Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spec	city Yes or No-	14. Race · Ameri	can Indian
98	or Ita	y Fur	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give			lexican, Puerto R	ican, etc.)	Black, White,	
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show alcal Examiner mant be notified at	ed by	3 Widowed 4 Divorced	Year or Dates:		ent's Usual Occupation		105	Specify: Sk	CC
215	within 72 ene. than "ns	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done during OO NOT use retired)	g most of working	g 16b.	Kind of Business/Ir	dustry
	filed withi Hygiene. other then		115) Da	le3 per	W		Shoes	
lanc	ould be f Mental F arkad ot atic eva	To Be	17. Eather's Name (First, Middle, Last)	. Broods)	1 18/	Mother's Name	(First, Middle, Maid	en Sumame)	
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	1 and 2 Health am 27		Diria Curtis	Mother	14934	Villa	Point L	le Abel	deent	la 2 1001
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re		cemetery, cren	sition (Nafhe of natory or other place)	10/29	20c.	Location - City or To	own, State
altir	injunit		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice se	e T	22	Name and Address of	Picility (2 Eng	m/ser	wee PA
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	ted sit	Examiner	Sequentially list conditions, if any leading immunications cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	menue of).					
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Box		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 2☐Feta 4☐Pregnant at time of d	l death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
P.0	that the de led by the detached	Phys	9 Unknown	9L Unknown					-	
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000	> 0 70	ompieted						24a. Was an		psy findings available
= E	The ate h page	Com						autopsy performed? Yes 2 \(\sigma\)	prior to con death?	inpletion of cause of 2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Other	Place of Death (
of		n: To	27. Manner ol Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury at		5 Residence d. Describe how inju	6 Other (Specify	1)
sior	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	ZZS	Work? 1 ☐ Yes	2000	Sist	Ect was	SK07
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	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medicai	one)	er: On the basis of examina and manner stated.	ition and/or invi	estigation, in my opinion	n, death occurred	at the time, date ar	id place, and due to	the cause(s)
ŀ	To Viti	~	29b. Signature and title of certifier	11		29c. License num			ate signed (Month, Lober 24,	
	n	9	30. Name and address of person who com	npleted cause of death (Item) 1 23a) (Type, P	sint)	_			
	ソ		MAMG. !	LIPPLISM	2	111 Penr	n Street	, Baltimo	ore, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Daly, Year) NOV 0 5 2004	32. Registrar's Signa	iture	books				

			1 - For State Registrar	State of Marylar	-	artment of H			giene Reg. No.	004	35063
	Physici	an	1. Decedent's Name (First, Middle, Last)	viola Ta	~			2. Date of Dea		Year	3. Time of Death
	/Medic Examin		4a. Faculty Name (If not institution, give s	treet/and number)	2		Location of Deat		1 4c. C	County of Death	×.7-7™
			Tuime (are.	Homewood		, ,	mok		7	City	
	Funeral Director		5. Social Security Number 6. Sex 1□	M 2 5 7. Age (In yrs.	O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.				lace (State or Foreign try)
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or La	cation	1,				0d. Inside City Limits
	Maryla f sho	tor	MD N/A		altimo						1 X Yes 2 No
	or 28e	Director	10e. Street and Number	306		10f. Zip Code 2121	0			en of What Coun	try?
	eath w	Funeral I	28 W. 27th Street	Apt. 306				nacify Var or No.		SA 4. Race - Americ	an Indian
9	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event, the Maddeal Evaninar must be notified at	Fun,	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	Vas Decedent of Hi fYes, specify Cuba I□Yes 2🍆 No	Specify:	to Rican, etc.)		Black, White,	
21215-0036	hours turel',	ed by	3 Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:		lent's Usual Occupa				Blad of Business/Ind	
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lary	2 should have and have is man	-	19a. Informant's Name/Relationship (Typ	e, Print)		g Address (Street a	and Number or Ru	ıra / Route Numbe	r, City or	Town, State, Zip	
	ges 1 and 3 t of Health if item 27 or other tr		Anita M. Pendleton 20a. Method of Disposition		920 M	etcalf Av	renue Apt	Date		N.Y. 104 ation - City or To	
mor	0 0		1XXBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	niiovas iroini State	emetery, cren pudon P	sition (Name of natory or other place		9/2004		imore	MD
Baltimore,	permit. Pages Department of Importent: if it any Injury or o		21. Signature of Funeral Service License		-	. Name and Addres		ARCH FUNI			
ш	20 E 8 9		23a. Part1. Enter the disease, or complic	ations that caused the deat		101 E.NOF				, MD 2	L202 Approximate
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30,	rate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
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Вох	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	an/Me	230. Was decedent pregnant	c. If yes, outcome of pregna		Ectopic pregnancy			23	d. Date of delive	гу
o.	at the deat by the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of d		Other (specify)	· · · · ·			Month	Day Year
Δ.	res that the igned by be detact		Part II. Dther significant conditions cont	ributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
Vital Records,	w requires been sign should be	ted by	Hyportusion)				1 🗆 Y	es 2 🗆	No 3 ☐ Proba	ably 4 Dunknown
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Οİ	s after or At Direct of Direct of Direct of the by	Certification:	4 Homicide determined	building, etc. (Specif	y)	, , , , , , , , , , , , , , , , , , , ,		City or Tow	n, State)		
	To the Hospitei or A within 24 hours after To the Funerel Director Completely filled in by	edicai (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the tim estigation, in my op	e, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) ar late and pl	nd manner as sta lace, and due to	ited. the cause(s)
	To th within To th comp	M	29b. Signature and title of certifier	>		29c. License			1	signed (Month, L	Day, Year)
	h			MO	00-1-05		05905	0	11/3	3/04	
	1)		30. Name and address of person who cor				yel Au	c Bal	1+	MD 212	17
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	+ MT Ros		15		-	
DHI	Registr MH 17 Rev 1/20			7 Juneara	19	Loon					

ORIGINAL

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend item#5,23a,2/per FH.ME.G838,12/18/04 TT.

D			Alliena / Unpe 1 - Stata Ragistrar	State of Man		r FH ME G artment of F rtificate of			jiene	n L	35064
		2.	Decedent's Name (First, Middle, Las	et)				2. Date of Dea		J 7	3. Time of Death
	Physic /Medi		Makai			Col	lins	OCTOBE!	R 28, 2	$0\overset{\scriptscriptstyleYear}{0}\overset{\scriptscriptstylear}{4}$	6:08p. M
	Examir		4a. Fecility Name (If not institution, give				r Location of Deat	h	4c. County	of Death	
9			UNIVERSITY HOSPIT		n sem done biothele d	BALTIMO:	RE If Under 24 Hrs				
9	Funeral Director		717. 71. (17.7)	7. Age (// ▼ M 2□ F	n yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	Coun	
7	TQ.		Usual Residence of Decedent			2.7		10 01	04	MD	<u> </u>
	arylan show d at	_	10a. State 10b. County	10	c. City, Town or Lo	eation				10	Od. Inside City Limits
	Be-f	Director	MD NA		Baltimo						XIXYes 2 □ No
	with t		10e. Street and Number 53 South Morley	. Chroot		10f. Zip Code	.229	1	0g. Citizen of 1	What Coun	try?
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28e-f show ant, tre Medical Exertinest be ricitied at	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13, 1	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-		e - America	an Indian
9	or Ita	Ξ	X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉No		f Yes, specify Cuba	an, Mexican, Puerl	o Rican, etc.)		ck, White, e	
93	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify	у: В	lack
15-	"nati	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	16b. Kind of B	usiness/Ind	ustry
12	withii iene. than	ошр	Elementary/Secondary (0-12) N/A	College (1-4or 5+) N/A	me. I	N/A	1)		N/	′ n	
p	s filed Il Hyg other	Be C	17. Father's Name (First, Middle, Last)	N/ A		N/A	18. Mother's Nan	ne (First, Middle, I			
/lar	should be nd Mental marked o	To B	Ronald Collins				Ebony	Talber	t		
Maryland 21215-0036	2 sho and is ma		19a. Informant's Name/Relationship (T			g Address (Street					Code)
	l and lealth im 27 her ti		Ebony Talbert-I		53 Sc	outh Mor	ley St				21229
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event, the Medical Exercitival he notified at once.		1 Surial 2 Cremation 3 1	Removal from State	cemetery, cren	natory or other plac	' I		20c. Location -	•	
Iţi	artme artme ortani injury		' 4 ☐ Donation 5 ☐ Other (Specify,			emorial		L/2/04 1	Randal	Isto	wn, Md
Ba	permit. Departr Importa any inju		Dlumi 3	State	M	Name and Address larch F/ 1300 Wab	H West	a. Balt	imore.	ма	21215
			23a. Pan 1. Enter the disease, or comp shock, or hear Vailure. List only of	lications that caused the	death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate
	Physician		Immediate Cause (Final disease or condition	a Fungal Pne							Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a co							
Н	- Adminior	10	Sequentially list conditions,	b. Due to for as a co	nse uence of						
	nted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Director Bar da di su	ria <u>e</u> d sauce out						
ć	execu an and rial-tra		that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	dicai		d							
9	ertifica ling ph	0	IF FEMALE:							f	
Вох	attending for use as	ian/	in the past 12 months?	23c. If yes, outcome of p 1☐Live birth 2☐ 4☐Pregnant at time	Fetal death 3	Ectopic pregnancy			23d. Dat Moi	e of deliver	y Day Year
P.O.	at the de by the tached	ysic	1 Yes 2 No	9☐ Unknown	ordeath 5	Other (specify)					
	es that igned b	by Physician/M	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contr	ribute to the	cause of death?
Records,	aquire en sig ould b	edt						1 ☐ Ye	s 2 No	3 Proba	bly 4 □Unknown
ecc	e law requ has been je 2 shoul	Completed						24a. Was ar		Vere autop	sy findings available pletion of cause of
= E		Con						✓ perform	ied? d	leath?	Pletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		045-		th Check only one)		
of	Phys this ral di	- T	Yes 2 No	1 Minpatient	2 ER/Outpatient	3 DOA Othe	4 Nursing H	ome 5 Resider			
lon	Attending I r death. actor: After by the funer	ation	Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	Work	(?) Yes 2 □ No	- Describe no	w injury occurr	ad	
Division	Attendi ar death. actor: A by the fu	iffica	3 Suicide 6 Could not be determined	28e. Place of Injury -	At home, farm, stre	et, factory, office		28f. Location (Str.	eet and Numbe	er or Rural	Route Number,
Ö	rs afte	Certification:	4 - Hornicas	building, etc. (S	pecily)			City or Town,	State)		
	To the Hospital or Attendinition 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	ical	Check only 2 Medical Exami	sician: To the best of my	knowledge, death	occurred at the tim	e, date and place, pinion, death occur	and due to the car	use(s) and mar	nner as stat	ted.
	To the within 2 To tha complet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License					
	£ ₹ 5		DA HADILA	long inch	7				d. Date signed		
			30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type F		.M.E.	00	TOBER_	29, 2	004
			CAROLH. ALLA	N md		l 11 Penn	Street,	Baltimore	e, Mary	land	21201
	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 0 5 2	32. Registrar's S		book			7		
			110100	TO I							

State of Maryland / Department of Health and Mental Hygiene 2004 35065 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10 20:21 M **Physician** MARIO T. CASINI /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ELKTON. UNION HOSPITAL 9. Birthplace (State or Foreign Country)

DA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □M 2 □ F PA 79 Yrs. 188 16 4528 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene. The start of tems 23a or 28a-f show sther then *natural; or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Modical Exercit at must be redified at NEW CASTLE NEWARK DE 1 ☐Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 19702 USA 115 BOYER DR. Be Completed by Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 ☑N'es 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes ZWNo Baltimore, Maryland 21215-0036 Specify: WHITE 3 O(Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GENERAL ELECTRIC MACHINIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fill if Health and Mental H item 27 is marked oth ASSUNTA DIFELICE ENRICO T. CASINI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4952 SHEPHERD ST., BROOKHAVEN, PA 19015 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is r sny injury or other traur ENRICO T. CASINI 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State SS. PETER & PAUL CEM. 11/2/2004 MARPLE TUP., PA * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 South Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Se Vann 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial infanction acute 2 days **Physician** /Medical Due to (or as a consequence of): Examiner S_grentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death signed by the a P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 No this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 27, 2004 DU047471 ostever laren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elkton, MD 21921 Suite 101 111 W. High Street Haron MD oshua 31. Date filed (Month, Day, Year) NOV 0 5 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Coster 1) enton 0530 M November 2 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Augsburg Lutheran Home</u> Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 17, 19 Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F Yrs. Director 212-05-5709 Maryland 90 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 6825 Campfield Rd., Apt 6D 21207 u.s. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: 3 Widowed 4 Divorced Year or Dates: 'naturel', White. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If itam 27 is marked other than "na any injury or other traumatic event, the Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Utility Company <u>General Supervisor</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Newton C. Coster, Sr. Martha Wirth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Coster (Son) 2905 Placid Drive, Baldwin, Maruland 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemeteru 11/4/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signaturs | Fune | Service License 9705 Belair Rd., Baltimore, Maryland 21236 116. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitet or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit attending physician and I for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 223No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2 KNo 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D37573 7,2004 Nov. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 37 11-015 MD 25 Marin MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MOV 0 5 2004 Registrar

			For State Registrar	State of Maryland	/ Department of Health and N Certificate of Death	fental Hygier		35067
			1. Decedent's Name (First, Middle, Last	^ .		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Edward			10 3	0 04	10 20 PM
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	1
	Funeral		5. Social Security Number 6. Se		birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign
	Director	Į	265-14-1220	M 20F 83	Yrs. Months Days Hours Min.	Feb. 6, 19	21 Fi	Örida
	and w		Usual Residence of Decedent 10a. State 10b. County /	10c. City, T	own or Location			10d. Inside City Limits
	Maryla f sho	to	Mariland N/	AIR	saltimore.			1 Yes 2 □ No
	h the or 28a a notili	Irec	10e. Street and Number	1 6	10f. Zip Code	10g. (Citizen of What Cou	untry?
	death with the Maryland ms 23e or 28a-f show rmust be notified at	Funeral Director	1234 Mapl	e Leat (t. 21202		USI	4
	er dez Items Det m	une	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036	J within 72 hours after death with the Marylan jien. I then "neturel", or Items 23e or 28e-1 show It e Modical Examiner must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 【 No Specify:		Specify: B	ack
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121	within ene. then "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use retired)	R	othloho	m Stool
N	filed Hyg Sthe Sthe		17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maid	en Sumame)	
lan	o d is D	To Be	Faward C	rawford	Jess	ie Wi	Mam	15
Mary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (T)	1) 11-11	19b. Mailing Address (Street and Number or Run		y or Town, State, Z	ip Code) 330,54
	1 and 1ealth om 27 ther tr		1VIS, Ernestir	e reek -		rrance 20c.	Location - City or T	1,TIOTIAA Town, State
altimore,	Pages nent of Hunt: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ B '4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	etery, crematory or other place)	2004 W	liami	Florida
altin	C 9 3		21. Signature of Funeral Service Licens		22. Name and Address of Pacility	Financi	Home.	1101100
ñ	permit. Depart Import any inj		Desept o	X. Kuss	Joseph L. Russ 2222 W. North Av	e. Balto	o. Md. 6	21216
			should, or heart failure. List only o	ne cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
H	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. wetaytat Due to (or as a consequent	ic concer from wale	BOWN DE	inai	catha
	Examiner			Due to (or as a consequen	nce org:	•		
L	n ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):			
	The law requires that the death certificate be executed the has been signed by the attending physician and tale has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	nce of):			
8760,	be ex sician burial		L	d				
687	ificate t g physi as the t	edical		U				
XO	eath certific attending p	an/M	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de			23d. Date of deliver Month	very Day Year
.O. B	ne dea the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	th 5 Other (specify)			24)
О.	res that the de signed by the a be detached f			ntributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	quires n sign uld be	ed by				1 🗆 Yes	2 No 3 Pro	obably 4 Unknown
Records,	aw require as been si 2 should t	Completed				24a. Was an autopsy	prior to o	topsy findings available ompletion of cause of
	The Tate his page	Com				performed 1 Yes 2	No death?	2□ No
Vital	icien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	Other	h (Check only one)	- May (2	w.,
	Phys or this eral di	1; To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury 28	Bb. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in		ny)
ion	ittending death. ctor: Afte / the fund	atlo	Natural 5 Pending investigation		Injury Work? M 1 Yes 2 No			
Division of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, St.		ral Route Number,
	ppitel ours a cours a	Ce	29a. Certifier Certifying Phy	vsician: To the best of my knowle	edge, death occurred at the time, date and place.	and due to the cause	e(s) and manner as	stated.
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	(Check only 2 Medical Examone)	iner: On the basis of examination and manner stated.	n and/or investigation, in my opinion, death occur	red at the time, date a	and place, and due	to the cause(s)
	vithi To ti	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month	n, Day, Year)
1			30. Name and address of person who	important cause of death //tem 0	3a) (Tuna Print)	22	11/1/04	
1	h		4.00 Hallarme	30	- 1	marc	mb =	21218
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	· e	7		
	Regist	rar	NOV 0 5 20	14 June	& sparker			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Matthew November 1, 2004 9:15 A M Aaron Cammarata /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4 B Oueens Bridge Ct. Cockeysville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
April 20, 1981 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 23 218-96-9562 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Cockeysville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #4 B Queens Bridge Ct. 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White <u>^</u> 3 ☐ Widowed 4 ☐ Divorced ear or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 12 N/A other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fil h and Mental H; r Is marked oth Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked of any injury or other traumatic eve once. Ronald Thomas Cammarata Marie Bonita Hittel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2322 Aquilas Delight, Fallston, MD Mr.&Mrs. Ronald Cammarata/Parents 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Nov. 4, XBurial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial Gardens 4 □ Donation 5 □ Other (Specify) Fallston, MD Signature of Funeral Service 22. Name and Address of Facilit Lemmon Funeral Home of Dulaney Valley 10 w. Padonia Road Timonium, MD 21093 Bryan Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line. Immediate Cause (Final disease or condition resulting in death) NATURAL Physician /Medical to (or as a consequence of) Examiner SEIZURE OTSORDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Lifer) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed STAFH CELLUCIATES and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed by should be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PORCHE GFHARTE BRA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? certificate has page 2 The 1 Yes 2 No or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2245 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Bodnar 515 Fairmount Ave. Suite 200 Towson, MD 21286 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Darius Couther
04-7092
AKG

Physician
/Medical
Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. cedent's Name (First, Middle, La 2. Date of Death **Physician** Month 145 18:48 PM November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1**≤**M 2□ F -39-1039 Director Yrs. an Residence of Deceden the Maryland 10a State 10b. County 10c. City, Town or Location 28e-1 show 10d. Inside City Limits Director 1 Nes 2 No and Numbe 10f. Zip Code 10g. Citizen of What Country? ISA or items 23e d Completed by Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other treumatic event, the Medical Examination 14. Race - American Indian. 1 and 2 should be filed within 72 hours after dealth and Mental Hygiene. Black, White, etc. I □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 1 € 0 Specify: 3 Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ary/Secondary (0-12) College (1-4or 5+) (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame Moller 19b. Mailing Address (Street and Number or Rural Route Number Department of Health a Importent: if item 27 is eny injury or other tre once. Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee lau 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Do not enter Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown 9 Unknown ۾ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To 1 Inpatient 20XER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Deceased 1 Natural 5 Pending Pedestrian struck by bus death. 2 Accident 11-2-04 6:00 P investigation 1 ☐ Yes 2 ☐ No after deat 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2700 Block Kirk AVC filled in by 4 Homicide within 24 hours a To the Funerel D Hospitei Bultimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene. 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ude october 30 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sykesuile
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Carrol 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 🗙 F 85 212-16-2194 Yrs. Director 04-19-1919 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits other treumatic event, the Medical Examinational Le notified at Director 1 X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 4709 Beaufort Avenue Items 23e Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 Is marked other than "naturel", or ther may injury or other treumatic event, the Medical Evan in a Once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 X Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Nurse Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Coates Maggie Coates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda A. Coates/ Daughter 4709 Beaufort Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 11-05-04 Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** stage End /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2. ₩ 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed? certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No 2 No the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours after Evnerel Dire letely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) more J. M. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 004 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Linda C. Carnabuci October 0 30 2004 8:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 765 - 222nd Street Pasadena Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2187 F Director 215 46 9599 58 Yrs Ĩ945 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location Itam 27 ia marked other than "natural", or Itama 23a or 28a-f show other traumatic evant, the Mudical Exameter must be notified at 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2 ☑ No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 765 - 222nd Street 21122 death U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 27 Married Baltimore. Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be fited within 7. In and Mental Hygiene. 7 Is marked other than "nu College (1-4or 5+) Elementary/Secondary (0-12) Professional Designer 12th Florist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert R. Bendall Lillian M. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an itam 27 ia Charles Carnabuci / Husband 765 - 222nd Street Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If its
any injury or ot 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bayview Crematory ¹ 4 □ Donation 5 □ Other (Specify) 11/2/2004 | Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ameroush 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician Long Cancer disease or condition resulting in death) Three /Medical Due to (o as a consequence of): mont **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or with that initiated events resulting in death) Last Examine Due to (or as a consequence of) sicien and burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the attending phy: IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy The law requires that the death 1 Live birth 2 ☐ Fetal death in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has autopsy performed: 1 Yes 2⊿No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 1 Natural 5 Pending after death. 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 124 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sure 300 OKNOT 900 BESTYON 32. Registrar's Signature State

Registrar

NOV 0 5 2004

			State of Maryland / Department of Health and N 1- State Registrer Certificate of Death		giene 004	35072
I	Physicia		1. Decedent's Name (First, Middle, Last) LEROY CRAWFORD	2. Date of Dea Month	Pay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1110	4c. County of Dea	
			BALTIMORE REHABILITATION EXTENDED CARE BALTIN	WRE	N/A	
	Funeral Director		5. Social Security Number 6. Sex 1	8. Date of Birth (Month, Day		thplace (State or Foreign ountry)
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary I sho	tor	MD N/A Baltimore			1 tes 2 □ No
	death with the Maryland ms 23a or 28e-f show rmust be notified at	Funeral Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What C	ountry?
	s 23a	ral	701 N. Arlington Ave. Apt. 502 21217		U.S.A.	
	ltams	nue	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes ≥ □ No		14. Race - Am Black, Whi	erican Indian, le, etc.
5-0036	I within 72 hours after death with the Marylan jiena. Ithan "natural", or Itams 23a or 28e-f show Ithe Medical Enaminet must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Specify: Blow	cK	Specify: B	lack
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7	within 72 ena. than "nai	шp	Elementary/Secondary (0-12) College (1-4or 5+)			
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ğ	d fall	To Be		Fields		
Mary	should and Men a marke aumatic	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rut			Zip Code)
	s 1 and 2 if Health itam 27 l			hpt. It _	Balto, MD	21228
Baltimore,	0 0		Deputial 2 Cramation 3 Intelligration State		20c. Location - City or	
			'4 Donation 5 Other (Specify) 21. Signally of Juneral Service Licens 22. Name and Address of Facility 14.	0-04	Durings Mil	s, MD
g	permit. Departr Importa					5. MD 21207
			23a Marri. Enter the disease, or complications that caused the doubt. Do not enter the mode of dying, such as cardiac shock, of heaft failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final	E		9 nset and Death
	/Medical Examiner		disease or condition resulting in death) Due to (or as a consequence of):			1 29
		-E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Universe or in Universe			
Ď,	e exection and an arrial-tr		resulting in death) Last Due to (or as a consequence of):			
8760	death certificate be executed e attending physician and at for use as the burial-transit	dicai	d			
× 6	leath certifica attending ph I for use as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery
Box	death a atten d for u	ician	in the past 12 months? I Dive birth 2 Fetal death 3 Ectopic pregnancy I Dive 2 Dip 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
o.	at the c by the tached	Physician/Me	9 Unknown			
Vital Records, F	requires that the de neen signed by the a hould be detached t	Completed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETIS MELLITUS		bacco use contribute t es 2 □ No 3 □ P	o the cause of death? robably 4 XUnknown
Ö	≥ □ ∅	plete	CHRONIC RENAL FAILURE	24a. Was a		utopsy findings available completion of cause of
Ä	Physician: The law this certificate has b al director, page 2 sl	Com	HY PERTENSION	perfor	med? death?	2 No
Ita	cian: ertifica actor,	Be (25. Was case referred to medical examiner?	th (Check only or	ne)	
	Physic this o	To	1 ☐ Yes 2 ★No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ★Nursing Ho		ence 6 Other (Spe	cify)
OUO	ding h. h. After funer	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 8b. Time of Injury Work? 1 Yes 2 No	200. Describe in	ow injury occurred	
Division of	al or Attending Phy safter death. I Diractor; After this d in by the funeral d	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	treet and Number or R	ural Route Number,
	rs after al Dir		a Tronicus	Ony or row		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	To the comp	×	29b. Signature and title of certifier 29c. License number 7 11 12 11 12 13 14 15 16 17 18 18 18 18 18 18 18 18 18	2	29d. Date signed (Mon.	h, Dey, Year)
•	ĥ		10 Name and address of access who completed cause of death (from 222) Time Print)	/	1-04-4	204
	')		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AURO CA C TAN 340) LOCH RAVEN BOULEVAR 31. Galavied (Month, Day, Year) 32. Registrar's Signature	RD, BAL	TIMORE, R	D 21218
	Sta Registi		31. Registrar's Signature 32. Registrar's Signature			

	1 - For State Registrar	State of	Maryland / [Departn <i>Certifi</i>	nent of He cate of D	ealth a Death	ınd Mei	ntal Hygi	en 20 ()4	35073
Physician	1. Decedent's Name (First, Middle, La	•					2.	Date of Death Month	Day	Year	3. Time of Death
/Medical	Helen Louise Coop							ovembe	r 1, 20	004	11:46 P M
Examiner	4a. Facility Name (If not institution, giv Gilchrist Center			4b.	City, Town, or L				4c. County		
Funeral	5. Social Security Number 6. S		Age (In yrs. last bin	thday) If I		OWSON		Date of Birth	Balti		place (State or Foreign
Director	181-18-9815	□M 2 X F	82	MAG	nths Days	Hours	Min.	(Month, Day, ep 13,		PA	ntry)
D .	Usual Residence of Decedent 10a, State 10b, County		10- Cit. T								
ehov	,		10c. City, Towr		n					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
the M	MD Howard 10e. Street and Number		Columb		of, Zip Code			10	a Citizen of V	What Carr	
Mith Ba or I Dir	9210 May Day Cour	+			1045				g.Citizen of V Inited		
uter deeth with the Mai r Itams 23a or 28e-f e iliner in ust be notified Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was I	Decedent of His	panic Orig	in? (Specify	Yes or No-			can Indian,
or its	1 Never Married 2 Married	Armed Force 1 Tes 2 If Yes, Give			specify Cuban es 2		Puerto Ric	an, etc.)		k. White,	etc.
ural', o	3 € Widowed 4 □ Divorced	Year or Date	es:		es 215140	Specify:			Specify	White	9
ed within 72 ho yglene. ner than "naturi it. Ine Mauical I.	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a.	(Give kind	Usual Occupation of work done du OT use retired)		of working		6b.Kind of Bu ocial		
withly lene. than	Elementary/Secondary (0-12)	College (1-4		recto:	· ·				dmin.	secu.	rcy
be filed tal Hyg d other event.	17. Father's Name (First, Middle, Last)					18. Mother	's Name (F	irst, Middle, M		Θ)	
Menta Menta arked atic ev	Charles Walford 1	Peterson			I	Ella	Мау К	eough			
2 sho and h is ma	19a. Informant's Name/Relationship (Type, Print)	19b.	. Mailing Ad	dress (Street an	d Number	r or Rural R	oute Number,	City or Town,	State, Zip	Code) 21043
end ealth m 27 her tr	Robert Cooper/Son				vernor (Grays					
Des 1 t of H if itel or oth	20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐	Removal from Sta	20b. Place of cemeter	Disposition y, cremator	(Name of y or other place)		Date NOV		Oc. Location -	City or To	own, State
t. Per rtmen rtent:	'4 □Donation 5 □ Other (Specification)			_	Cremato		200	_	eltsvi		MD
permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event. The Maryland Estaninar must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licer	1500	M00984	22. Nan Cre	me and Address	of Facility and I	Funera	al Alte			
	23a. Parti. Enter the disease, or com	plications that cau	sed the death. Do n		7 Green				Balti	more,	Approximate
Physician	Immediate Cause (Final	one cause on eac	n line.								Interval Between Onset and Death
/Medical	disease or condition resulting in death)	aDue to (or	as a consequence of		er - V	rer.	AJTA.	tic			nents
Examiner	Conversiothy link and divinue	b		,							
ner a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence of	of):							
executed an and rial-transit Examine	Cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
cate be executed physician and the burial-transit dical Examin		Due to (or	as a consequence o	or):							
physicie s the burst the b		. d								-	
To the Hospitel or Attending Physician: The law requires that the death certification 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as Medical Certification; To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	e of delive	erv
nat the death certi d by the attending letached for use a Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnan	n 2 ☐ Fetal death t at time of death		pic pregnancy er (specify)				Mor		Day Year
by the staches	9 □ Unknown	9∐ Unknowi									
igned be de	Part II. Other significant conditions of	ontributing to deat	h but not resulting in	the underly	ing cause given	in Part I.		_			e cause of death?
een s hould							-	1 ☐ Yes	2. X No	3 Prob	ably 4 Unknown
The law requir cate has been s page 2 should	ļ							24a. Was an autopsy	p	rior to con	osy findings available npletion of cause of
sician: The law certificate has b irector, page 2 s								performe 1 Yes 2	No 1	eath? Yes	2 No
ysiclan: is certific director,	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ADER/O					heck only one)			
or this eral d	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inp	njury 28b. T	ime of	28c. Injury a	t	sing Home 28d.	5 ☐ Residen Describe how	ce 6 K JOthe injury occurre	er <i>(Specify</i> ed	Hospice
Itel or Attending P rs after death. el Director: Atter t led in by the funera Certification;	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year) In	njury M	Work?	s 2 🗆 No	О				
r Atte	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	Injury - At home, far etc. (Specify)	rm, street, fa	ictory, office			Location (Stre City or Town,		r or Rural	Route Number,
rs after or rel Dil		Dollowing,	oto. (opoony)				1		Olale)		
To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Medical Certification;	(Check only 2 Medical Exan	nner: On the basis	st of my knowledge, s of examination and	, death occu	irred at the time, ation, in my opin	date and ion, death	place, and occurred a	due to the cau	se(s) and mar	ner as sta	ated. the cause(s)
thin 2 thin 2 omplet	one) 29b. Signature and title of certifier	and manner	stated.		29c. License n						
+ × + 8	MA M	m Al	in last	2	025	215			I. Date signed		2, 2005
5000 E	30. Name and address of person who	completed cause	f ath (Itam 23a) /	Type Print	400	01 M	Char	les St			1-007
20	WA. R. Ley	opiotod cause	dir (nam 20d) (17 Pa, CIIII)			MD 2		IEEL		
State	31. Date filed (Month, Day, Kear)		strar's Signature	4			, 2				
Registrar	NOV 0 5 20	U4 124	neva /		porés	/					

Baltimore, Maryland 21215-0036

@ =:40 PM

HELEN COOPER - NOVEMBER 1, 2004
Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygien Q O I

	Sec.	~	-	
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	5	1 1	- 1	4
	v	v	- 1	-

			1 - State Registrar	State of Marylan	Cei	tificate of	Death		16112 U U 4	35074	
	Physici /Medi		1. Decedent's Name (First, Middle, Last CHARLES, E	-16 .	erLin)		2. Date of Deat Month NOVEMBER	R 2,2004 ^{Year}	3. Time of Death 11:52A. M	
	Examir		4a. Facility Name (If not institution, give 1027 LAKEFRONT DRI			4b. City, Town, o	r Location of Death	1	4c. County of Deat HARFORD	h	
	Funeral Director		5. Social Security Number 6. Se 2/3-66-5648 Usual Residence of Decedent	7. Age (In yrs.)	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7-26 3,	Year) 9. Birth Co.	hplace (State or Foreign	
	show	٥٢	10a. State 10b. County HARG		y, Town or Lo	_				10d. Inside City Limits	
	ith the Marylar or 28a-f show	Director	10e. Street and Number			CDGEW 10f. Zip Code		10	0g. Citizen of What Co		
936	72 hours after death with the Maryland natural', or itams 23a or 28a-f show disal Examir or must be notified an	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1		ID40 lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White	nican Indian, e, etc.	
Maryland 21215-0036	c = 0	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Deced (Give life.	lent's Usual Occup kind of work done OO NOT use retired	ation during most of world)	king	16b. Kind of Business/		
1212	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	Com	17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4 4RS		SUPERUI.	SOR	ne (First, Middle, N	LIGHT	RAIL	
ano	ould be to Mental I arked of atic eve	To Be	A.	Berlin					GELMIRE		
Mary	コニトゴ	-	19a Informant's Name/Relationship (7)	rpe, Print)			and Number or Ru	ral Route Number,	City or Town, State, 2	ip Code)	
	iges 1 and it of Healt if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 ☐ F	teillovai iloilli State		sition (Name of natory or other place		Date 2	20c. Location - City or		
Baltimore,	permit. Pag Department Important: Ii any injury o		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Six dure of Funeral Service Licensee 11 State 22. Name and Address of Facility 11 State 22. Name and Address of Facility 12 STELLA FUNERAL HOME 13 HARTIEY MILLER - STELLA FUNERAL HOME 15 27 has Food RO BA Ho No 21234								
	Pnysician /Medical Examiner		28a. Pagt 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line. a	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a consequ							
68760,	icate be ex physician s the burial	Medical E		Due to (or as a consequ	ence or):				-		
.O. Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli-	very Day Year	
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significent conditions co	ntributing to death but not resu	ilting in the ur	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
Vital Records,	The larate has	e Completed	25. Was case referred to medical						ed? prior to c death? No 1.2 ves	opsy findings available ompletion of cause of 2 No	
fVii	ye dir	To Be	examiner?	fospital: 1 Inpatient 2 E	ER/Outpatient	3□ DOA Othe		h <i>neck on one</i> ome 5 ☐ Resider	ce 6XIOther (Spec	WSCENE	
Division of	ng fter ine	Certification;	27. Manner of Death 1	28a. Day of Injury (Nonth, Dily Year) (28e. Jace Injury - At horbuilding, etc. (Specify,	28b. Time of Injury O	28c. Injury Work M 1 1	yat (? Yes 200No	28d. Describe how	vinjury occurred	self	
Q	Hospital 4 hours a Funeral I ely filled	edical Cer	29a. Certifier 1 Certifying Phy	sicien: To the best of my know ner: On the basis of examinati and manner stated.	viedge, death	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	D27 Ca	Ke Front	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of contilier	lemp		29c. License	·M.E.		d. Date signed (Month,		

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

NOV 0 5 2004

J. LARON LOCKERMO

Sparks

ORIGINAL

111 Penn Street, Baltimore, Maryland 21201

	1 - For Stata Registrer	Siale	OI WATYLE	C	partment of H ertificate of I	Death	and M	енан пу	/gien (Reg. N]4	3507
an	Decedent's Name (First, Middle							2. Date of D		av	Уваг	3. Time of Death
al	Mary E.		aney					Novemb			ð04	11:25 A
er	4a. Facility Name (If not institution	-	·		4b. City, Town, or				44	C. County	of Death	ndol
-	North Arundel 5. Social Security Number	Hospital		rs. last birthda		Burni If Under 2		8. Date of Bi	dh	Anne		
	216-34-4577 Usual Residence of Decedent	1 □ M 2 🖾 F		67 Yrs.	Months Days	Hours	Min.	Aug. 1	ay. Year	37	9. Birthp Cour	place (State or Fore
	10a. State 10b. County		10c.	City, Town or	Location						1	0d. Inside City Lim
ō	Maryland Anne	Arundel			Pa	sadena	а					1 ☐ Yes 2 🔀 i
Directo	10e. Street and Number	711 diraci			10f. Zip Code	0440111			10g. C	itizen of V	Vhat Cour	ntry?
	192 10th Stree	et				21122	2			U	ISA	
Funeral	11. Marital Status	12. Was D	ecedent Ever in Forces?	U.S. 1	3. Was Decedent of Hi If Yes, specify Cuba	ispanic Orig	gin? (Spe	cify Yes or N	0-			an Indian,
Fu	1 ☐ Never Married 2 🔀 Mari		s 2 XNo		1 ☐ Yes 2 🔀 No	Specify:	, ruento e	nican, etc.)			k, White,	
d by	3 ☐ Widowed 4 ☐ Divorced		r Dates:		103 202110	ороспу.				Specify	· Wn	ite
Completed	15. Deceden (Specify only higher	t's Education at grade complete	∍d)	(Gi	cedent's Usual Occupa ve kind of work done o . DO NOT use retired	during most	of working	ng	16b. l	Kind of Bu	ısiness/Ind	dustry
dmc	Elementary/Secondary (0-12)	Colleg	e (1-4or 5+)	inte	Homemake	•				Hous	eho1	d
e Co	17. Father's Name (First, Middle,	Last)	· · · · · · · · · · · · · · · · · · ·		Homemake		r's Name	(First, Middle	, Maidei			
0 0	Charles F					Gra			ning		-,	
-	19a. Informant's Name/Relations			19b. Ma	iling Address (Street a			l Route Numb	er. City	or Town.	State. Zip	Code)
	Wayne B. Chane	y (spe	ouse)		10th Stre							,
	20a. Method of Disposition			. Place of Dis	position (Name of	١ ١ ١	D	ate	20c. L	ocation -	City or To	wn, State
	1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		om State		rematory or other plac ven Cemete		Noy0	04	Gle	n Bu	rnie.	Marylan
	21. Signature of Funeral Gervice		1		22. Name and Addres	_			as F	unor	al Ho	me, P.A.
	Mud &	7			3111 Mou	ntain						
T	23a. Part1. Enter the cisease, or shock, or heart fullure. List	complications the	at caused the de	eath. Do not e	enter the mode of dying	g, such as o	cardiac o	r respiratory a	rrest,	^		Approximate Interval Between
	Immediate Cause (Final			oft For	2112				1		1	Onset and Death
	disease or condition resulting in death) a. Fracture Left Femur Due to (or as a consequence of):						-/		3 hours			
	Fat ombolism						-1	/	18	s hous		
ner	if any, leading to immediate	Sequentially list conditions, if any, leading to immediate cause. Enter Unide living Cause (Disease or injury Cause (Disease or injury Cardionul monary								IN.		s hous
Examiner	that initiated events	0.	diopulmo		ırrest				_ X	EXAMINE	R	Lours
	resulting in death) Last	Due	to (or as a cons	equence of):	uence of):					EXH		
licai		d					MOITA	APPROYED BY				
Mec	IF FEMALE:					U 071	FICATION			-		
hysician/Medic	23b. Was decedent pregnant in the past 12 months?	1 Liv	outcome of preg e birth 2 Fe	etal death 3	□Ectopic pregnancy		-			23d. Date Mor	e of delive	ry Day Year
/sic	1 Yes 2 No		egnant at time o iknown	f death 5	Other (specify)					14101	1011	Day Toal
Δ.	Part II. Other significant condition	ns contributing to	o death but not r	esulting in the	underlying cause give	an in Part I		23e Did	nhacco	use contr	ibute to th	e cause of death?
ò	Rheumatoid			oodaang ar are	underlying oddse give	armir anti.			Yes 2			ably 4 Unknow
eted	Milealia cora	ar cili i ci	3							. JAJ 140		abiy 4 Donkhor
ompl								24a. Was	psy	р	rior to con	osy findings availab npletion of cause of
Ö								1 ☐ Yes	rmed? 2 🌠 No		eath?	2□ No
Be	25. Was case referred to medical examiner?	Hospital:			Otho		of Death	(Check only	one)			
2	1 X Yes 2 No 27. Manner of Death	1		ER/Outpati	- Annual Control	4 🗀 (40)	sing Hor	ne 5 Resi)
Certification:	1 Natural 5 Pendin	g (M	lonth, Day Year)	0 4 5	Work	:?	10	ed. Describe COIIas				
ical	2 X Accident investig	not be			A ^M 1□ 1 street, factory, office	∕es 2.1XIN		broke				Route Number,
ertii	4 Homicide determ	ined 200. Fit	ilding, etc. (Spe	cify)				City or To	wn, State	192	19t	h Street
	29a. Certifier 1 Certifyin	o Physicien: To	the hest of my k	HOME	ath occurred at the tim	e date and	I place o					
edical	(Check only 2 Medicel one)	Examiner: On the	e basis of exami anner stated.	nation and/or	investigation, in my op	oinion, death	h occurre	d at the time,	date and	d place, a	nd due to	the cause(s)
Me	29b. Signature and title of certifie			ysic	29c. License	number			29d. Da	ite signed	(Month, L	Day, Year)
		monor	and a	10		77						
	'4// /		_		D449	4/5			Nove	$\Delta mr \Delta r$		Z 1 11 1 Z 1

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

M.D., 325 Hospital Dr., Glen Burnie, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gurmeet S. Sawhney,

			1 - For State Ragistrar	State of Maryl	and / Depa <i>Cer</i>	artment of F <i>tificate of</i>	lealth and M Death	ental Hygie	2004	35076
	Q.		Decedent's Name (First, Middle, Last	it)			200111	2. Date of Death		3. Time of Death
	Physici /Medic		Donald	Cooper				October	Day Yea	
	Examin		4a. Fecility Name (If not institution, give	street and number)		-	or Location of Death		4c. County of De	
		À	University of Mas						NIA	
г	Funeral		5. Social Security Number 6. S	STM 2□F	vrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. E	Birthplace (State or Foreign Country) Colorado
Н	Director		572-78-8365 Usual Residence of Decedent	54				March 2	6,1950 (Colorado
	yland		10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	Maryland	N/A			Baltimore	e City		1 X Yes 2 No
	ith th	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What	Country?
	ath w		538 Carrollto				21223		United	d States
	ter de	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever i	n U.S. 13. V	Vas Decedent of F f Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	neńcan Indian, hite, etc.
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examilian salt be notified at	by Funeral	3 ☐ Widowed 4 ☑ Divorced	1 ∐Yes 2 ∑tNo If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	White
Š	2 hou		15. Decedent's Ed		16a. Deced	lent's Usual Occup	pation	16	6b. Kind of Busines	
215	thin 7 e.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	lite. L	kind of work done DO NOT use retired	during most of working d)	ng		
2	ed wi ygien nar th	Con	8 Years		E1	ectricia	in		Electrica	al Contractor
and	be fill ntal H ad oth	Be	17. Father's Name (First, Middle, Last)			,	18. Mother's Name			
3	d Mer narke natic	으	Robert E. Coope		401 14 10			na J. Pu		
Maryland 21215-0036	d 2 sl th and th si traur		Mrs. Ginger Bronk	• • •			and Number or Rural Avenue		City or Town, State Ore, MD	, <i>Zip Cod</i> e) 21219
	tam 2		20a. Method of Disposition		b. Place of Dispos	sition (Name of	D:		c. Location - City of	or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or flems 23a or 28a-f ehow any injury or othar traumatic event, the Madical Examinations as the relitted at once.		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Dopetion, 5 ☐ Other (Specify			Service	Corp. 11/			Maryland
alti	mit. i partm sorta / inju		21. Signature a Funeral Service Licen		#		ss of Facility Funeral Ho		<u>.</u>	
Ö	Deparenti Impo any in		Y Wedler	grill!			runeral Ho ve. Dunda			lnc.
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	ications that caused the done cause on eagh line.	leath. Do not ente	or the mode of dying	ng, such as cardiac or	respiratory arres	y 10110 2.	Approximate Interval Between
H	Pnysician		Immediate Cause (Final disease or condition		tic disc	ase of.	the lune			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):)		C METTERS
Н	Lamino	Į.	Sequentially list conditions,	b. Malian Due to for as a con	ant m	elanon	10			1 year
	red nsit	nine	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence or).					/
Ć,	execun and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a con-	sequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical Examiner		d						
	rtifica ng ph as th		IC SCHALC.							
Вох	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	by Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	,		23d. Date of d	,
0.	ie dea the at	/sicl	1 Yes 2 No	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year
Q	that the	Phy	Part II. Other significant conditions of	entributing to death but not	resulting in the un	deriving cause giv	en in Part I	23e Did tobar	co use contribute	to the cause of death?
ds,	uires sign				•	,				Probably 4 Winknown
CO	w req	lete						24a. Was an	24h Were :	autopsy findings available
Re	The la te has age 2	Completed						autopsy performe	d? prior to death?	completion of cause of
ital	ian: rtiflica stor, p	a	25. Was case referred to medical				26. Place of Death	1 Yes 2 (Check only one)	No 1 Ye	s 2 No
_f <	ysic lis ce	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Oth			e 6 □Other (Sp	ecity)
п 0	ng Pl	ou:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injun Worl		3d. Describe how		
sio	tendi leath. tor: A the fu	catl	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 □No			
Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	it home, farm, stre ecify)	et, factory, office	28	Bf. Location (Stree City or Town, S		Rural Route Number,
_	spital ours naral filled		29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge death	occurred at the tim	ne date and place as	nd due to the caus	ra(s) and manner a	as stated
	To the Hospital or Attending Physician: The law within 24 hours after death. To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examone)	inar: On the basis of exam and manner stated.	ination and/or invi	estigation, in my of	pinion, death occurred	d at the time, date	and place, and du	e to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To tha Funaral Director: After this certifica completely filled in by the funeral director, p	Me	29b. Signature and title of certifier	1		29c. License	e number	29d.	Date signed (Mon	ith, Day, Year)
)	1		Steph	LI MI	>	P18	659	C	Ctober :	31. 7.004
	b		30. Name and address of person who o	ompleted cause of death (tem 23a) (Type, F	rint) UNIVER	STY OF MARY	LAND MEDI	CAL CENTE	R 21208
			STEPHEN LIA	32. Registrar's Signature	22) OUTH G	GREENE 5	TREET, E	BALTIMORI	E, MARYLAND
•	Sta Registr		100 Q 5 2004.	Legistrar's Si	19 h	books				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Calabrese, Jr. Joseph S. 7:30 p.M October 31, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samaritan Nursing Center 8. Date of Birth (Month, Day, Year) Feb. 28, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F 5. Social Security Number **Funeral** Months Days Hours 86 Ĩ918 Texas 214-01-5618 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evans are must be routing an ance. 1X Yes 2 □ No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1405 Walker Avenue 21239 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 yrs. College (1-4or 5+) Lutheran Church Church Sexton 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (Joseph S. Calabrese, Sr. Rose Triesta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Alexander C. Calabrese /wife 1405 Walker Avenue Baltimore, MD 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/4/04 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael E. Canapp 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure Physician /Medical Due to (or as a consequence of) Hypotension 3weeks **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardiomyopathe physician and s the burial-translt Physician: The law requires that the death certificate be executed Ischemic Due to (or as a consequence of): Box 68760. Atheroscierotic Cardiovascular Disease Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Alzheimers Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 Z No Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3□ DOA 2 PER/Outpatient 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide in by 4 Homicide within 24 hours after To the Funeral Dire (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 1, 2004 D40277 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD 5601 Lock Rowen Blud Baltmore, MD 21239 S. Wilson Thomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2004 35078 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year /Medical DONALD P. COOK II NOVEMBER 2004 11:00p 4a. Facility Name (If not institution, give street and number) IRVINGTON Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE NURSING CENTER @ BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**½** M 2□ F Days Hours 51 Yrs. Director 217-56-7678 5-12-1953 MARYLAND Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28e-f show treumetic event, the Madicul Example must be notified at Director MD. N/ABALTIMORE TX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5218 WILTON HEIGHTS 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√∃Xes 2 ☐ No IfYes, Give-Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene.
Inter if item 27 is marked other then "naturel", or ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DONALD P. COOK SR. EVA WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5218 WILTON HEIGHTS BALTIMORE, MARYLAND 21215 YVONNE A. COOK(WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11-9-2004 20c. Location - City or Town, State 1 Burial 2 Cremation ö 3 □Removal from State ortent: i 4 □ Donation **/**5 □*Ø*ther *(Specity)* GARRISON FOREST VETERANS BALTIMORE, MARYLAND permit.
Deporte
Importe
any inje JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Part / nter the disease, or complications that caused the death. show or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Landrising Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/04 D4768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaymond Miller 25 Main Thur Suite Kenterburn MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 5 2004 Registrar

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	Physici		1. Decedent's Name (First, Middle, Las	Shavis				2. Date of Death Month	Day Year	3. Time of Death 9:80 A M		
	/Medio Examir		4a. Facility Name (If not institution, give	street and number	epital	4b. City, Town, or Lo	ocation of Death	77.00	4c. County of Dea			
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthday) 75 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 9-21-19		thplace (State or Foreign ountry) TTH CAROLINA		
	/tand		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	a Man	ctor	MD. N/A		BALTIMO	RE				1 ŽYes 2 ☐ No		
	with the a or 24	Dire	10e. Street and Number 1626 N. APPLETON	T CT		10f. Zip Code 21217		100	g. Citizen of What C USA	ountry?		
336	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show he Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? W∑Yes 2 □ N If Yes, Give Year or Dates:	0	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.		
2-0	72 hou	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occupation kind of work done duri	on ina most of workin	16	b. Kind of Business	/Industry		
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-) life.	DO NOT use retired) RECONSTRUC	_	.9	CONCEDITO	TT ON		
	Hygi Hygi ther nt,	Be Co	17. Father's Name (First, Middle, Last)		KOAD			(First, Middle, Ma	CONSTRUC	TION		
ylar		To B	THOMAS CHVIS				FODIE	McNAIR				
, Maryland	nit. Pages 1 and artment of Health ortant: If item 27 injury or other tr		9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10c CHAVIS (WIFE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10c APPLETON ST. BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of 11 1 Rate) 004 20c. Location - City or Town, State									
Baltimore,			a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11-1 2004 20c. Location - City or Town, State CARRISON FOREST VETERANS WINGS MILLS, MARYLAND 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217									
Ä	Depa Impo any ir	1 9) (farath)	J. Hus	re 1	721-27 N.	MONROE S	T. BALTI	MORE, MAR			
	Physician /Medical	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a							Approximate Interval Between Onset and Death			
	Examiner		Sequentially list conditions.	b	consequence of):							
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):							
68760,	ficate be executed physician and is the burial-transit	edical Exa	resulting in death) Last	Due to (or as a	consequence of):							
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O. Box	that the death certiff led by the attending detached for use as	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
ords, P	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause given i	in Part I.			o the cause of death?		
Vital Records,	The ate h page	Completed						24a. Was an autopsy performe 1 Yes 2	d? prior to death?	utopsy findings available completion of cause of 2 No		
<u>S</u>	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2 ☐ ER/Outpatier	Other	6. Place of Death		- 0 Flore (0			
S S S S S S S S S S S S S S S S S S S								cify)				
Division	i Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	y - At home, farm, str (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Re State)	ural Route Number,		
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner state	examination and/or in	h occurred at the time, vestigation, in my opini	on, death occurre	d at the time, date	and place, and due	to the cause(s)		
;	T With	×	29b. Signature and title of certifier	last CH	not, as	29c. License no	umber 152195		Nov 2	h, Day, Year) 2004		
1	alt.		3). Name and address of person who o	ompleted cause of de	mth (Item 23a) (Type,	Bon ,	licour	o Ha	spital	,		
	Sta Registr		3Y. Date filed (Month, Day, Year) NOV 0 5 2004	32. Registrar	's Signature	park			J			
DH	MH 17 Rev 1/2	001		7	1							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 24a per mrs 37 11-5-04 yr State of Maryland Department of Health and Mental Hygiene 0 0 4

35080 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Debra Bernadette Domneys 4:40 PM NOV 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Union Memorial Hospital Balto 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7-18-1966 Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days Months Hours 220-86-4394 38 Director Md Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 7 is marked other then "neturel", or items 23e or 28a-f show treumatic event, If a Modical Extraller rust be nutified at 10d. Inside City Limits N/A Md Balto 14 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5602 Albanene Place 21206 USA permit. Pages I and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If tem 27 is marked other there are injury or other treummits. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2XXVo Black. Specify à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Packing 12th grade Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James O. Domneys Barbara A. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wilson - Mother 720 N. 6th Street Neward, N.J. 07107 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/6/2004 King Memorial Park Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) ture of Runeral Service Ch 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Pneumonia 5 WKS /Medical Due to (or as a consequence of): Examiner Sepsis Wils Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed as the burial-transit Seizures WKS and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical CLL 3 yrs 050 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 8 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an X Yes 2 □ No ospitel or Attending Physicien: hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 uneral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No tilled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide To the Hospitel within 24 hours a To the Funerel C Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kameel a. M.D. Bangeruce IST AT 2438946 November 30. Name and abdress of person who completed cause of death (Item 23a) (Type, Print) BANGORIA EAST UNIVERSITY PARK WAY BALTIMORE MO 21218 KAMALKUMAR 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NUV 0 5 2004 Souls Registrar

04-7014 B.K.S ROBE

ERT	DAVIS		Amend Item 18 per the G838 12-8-04 to G837 to	as artment of Health and Me 1-8-04 Las rtificate of Death	ntal Hygier	2004 3	35081
	Physici	an	1. Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death 1903 P M
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	OCT. 30	2004 4c. County of Death	
3	LAdiiiii	ici	BON SECOURS HOSPITAL	BALTIMORE CITY		NA	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Yes	9 Birthplace 9 Birthplace 9 Country	ce (State or Foreign Y) Yand
2	how		10a. State 10b. County 10c. City, Town or Le	ocation		100	d. Inside City Limits
2	8e-fe	Director	Maryland NA Balt	imore_			1 X Yes 2 □ No
4	a or 2	Dir	10e. Street and Number AHO F RIALI & C+	10f. Zip Code	10g. (Citizen of What Country	ls.
4	ms 2:	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	ty Yes or No-	14. Race - American Black, White, etc	
21215-0036	ges I and 2 should be filed within 7.5 hours are bean with the waryand. It feeling 21s and Monthal Hygiene. It frem 21s marked other than "naturel", or items 23s or 28e-f show or other traumatic event, the Modical Examinar must be notified at	d by Funeral	1 Ves 2 Nover Married 2 Married 1 Yes 2 No	1 Yes 2 No Specify:	Sair, 610.)	Specify: Bla	ck
15-	"nate	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Indus	stry
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	tal Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		en Sumame)	
Maryland	z snould be med withing and Mental Hygiene. is marked other than aumatic event, ILEMS	은	19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Maili	ng Address (Street and Number or Rural F		v or Town State Zin C	(ode)
	and 2 s lealth an m 27 is her trau		Ms. Felicia Davis 281	4 E. Jefferson	St. P	Salto Md	21203
ω,	permit. Fages I and Department of Health Importent: If item 27 eny injury or other tr once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Dispocemetery, cre	metory or other place)		Location - City or Town	n, State
tim	ant:		'4 □Donation 5 □ Other (Specify)	allie	1004 D	undalK	Md.
Ва	Departr Importe any inje		Joseph L. Russ Z	2. Name and Address of Facility CST L. CUS Fr	ingral	Home, 21	1516
	377		23a. Par I Enter the displace, or complications that comed the death. Do not enter the displace in the displac		espiratory arrest,	A	approximate nterval Between
	hysician		disease or condition and the condition and the condition and the condition are utilized as a condition and the condition are utilized as a condition and the condition are utilized as a condition and the condition are utilized as a condition are utilized as a condition are utilized as a condition are utilized as a condition are utilized as a condition are utilized as a condition and the condition are utilized as a condi	rdiovascular Diseas	e		Inset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
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	and transil	Examiner	causa. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	law requires that the beath certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dlcal E	Due to (or as a consequence of):				
د 68	ing phy e as th	a)	IF FEMALE:				
Вох	inat the death certific ed by the attending p detached for use as	by Physiclan/M	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Da	ay Year
0	by the	hysi	1 Yes 2 No 9 Unknown	2 0 11 01 (0) 20 11 / 1			
S,	res mar signed t		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the d	
Records,	been si should	eted					dy 4 Unknown
C	the law	Completed			24a. Was an autopsy performed?	24b. Were autopsy prior to complete death?	
		Be C	25. Was case referred to medical examiner?	26. Place of Death (C	1 AYes 2 N Check only one)	No 1 Yes 2	□ No
of V	rnysician: this certific ral director,	ို	1 XYes 2 No Hospital: 1 Inpatient XX ER/Outpatier		5 Residence	6 ☐ Other (Specify)	
	After After fune	tlon	27. Manner of Death 1 TNatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No	d. Describe how inj	ury occurred	
	a or Attendor after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f	Location (Street a City or Town, Sta	and Number or Rural R ite)	oute Number,
	To the Hospitel or Attending Prowithin 2 Hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death and manner stated.	h occurred at the time, date and place, and vestigation, in my opinion, death occurred	due to the cause(at the time, date a	s) and manner as state nd place, and due to th	e cause(s)
	Nithi To th	Ž	29b. Signature and title of certifier Panak— Southull, MD	29c. License number O.C.M.E		OCT . 31, 2	
20			TWINGLE L. SUCCITORITY, 1740	nn Street, Baltimor	e, Maryl	and 21201	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DHM	IH 17 Rev 1/2	- 13	31. Date filed (Month, Day, Year) 32. Registrar's Signature ORIGINA	Market			-
			ORIGINA	ĀL			

State of Maryland / Department of Health and Mental Hygien [] [] 35082 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death Yea **Physician** 3 :30A.M 2004 /Medical 4c. County of Dea 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE REHABILITATION EXTENDED CARE MOKE If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days Months Hours 15 M 2 F 219-52-646 Usual Residence of Decedent 55 Director arolona filed withIn 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-1 show 1 Yes 2 No Director minster arro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2115 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 € Married 2 No Baltimore, Maryland 21215-0036 1 Yes 27 No Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver 12 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages t and 2 should be inent of Health and Mental Innt: If item 27 is marked o Mae Julia 2 Dupree rank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S. te, Zip Code) Wastminster Clizabeth 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it 3 □Removal from State 1 Surial 2 □ Cremation 3 □ F
4 □ Donation 5 □ Other (Specify) injury or Cem NOV 8 Forest Ust 2004 - Funeral Service P.A. 21. Signature of Funeral Service Licensee 2. Named and Address of Facility Cost any in etan St. Balt. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TOMA Immediate Cause (Final disease or condition resulting in death) MULTIFORME 5 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy perform rmed? 2 **X** No 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 [] Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural
2 Accident or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Thomicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH BOULEVARD BALTIMORE 60 . Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 5 2004 Registrar

Diane O'Brien Dickerson

OA 07027

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RPD 35083 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 0640 P M Diane O'Brien Dickerson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 16511 Trenton Road Baltimore Upperco If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 55 Yrs. Director 214-52-1098 31, Maryland Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examinar must be notified at 1 □ Yes 2 No MD Baltimore Upperco Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21155 16511 Trenton Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ Z No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced "natural" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Public Education Elementary/Secondary (0-12) College (1-4or 5+) Teacher $5 \pm$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Heelth end Mental Hent: If Item 27 Is marked ott James O'Brien Dickerson Gladvs Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jay Miller/Husband 16511 Trenton Road, Upperco, MD 21155 other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place) Nov 2 ö permit. Page Department of Importent: If any Injury or once. Beltsville, MD Chesapeake Crematory 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M00986 Halile 8717 Green Pastures Drive Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the eld d be detached for □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed' certificate Yes 2 🗆 No Yes 2 No or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1XYes 2□No Hospital: Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) At Scene Certification: To this completely filled in by the funeral 28a. Date of Injury 28b. Time of Injury 28c. 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Shot death. 6:30PM 1 Yes 2 No 10-31-04 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide nea within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st Lev.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) O.C.M.E. November 1, 2004 ne and address of person who completed cause of de (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 D 32. Aegistrar's Signature 31. Date State Registrar

State of Maryland / Department of Health and Mental Hygier 0 1 1 - For Stata Registrar 35084 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 335 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death A-001 Examiner CARROLL DRIVE 110 Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 12M 20 F 214-20-95 Director NOU 16,1926 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked othar than "natural", or Itams 23e or 28e-f show other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Director MD CARROL WestMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APPT 225 FROCK U.S.A DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Tes 2 ☐ No U.S. If Yes, Give Year or Dates: NAV 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2□ No Baltimore, Maryland 21215-0036 Specify: Specify: white Be Completed by 3 Widowed 4 Divorced NAVY 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked othar than Elementary/Secondary (0-12) College (1-4or 5+) 1246 CAR CORP. DRIVER permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked oths any injury or other traumatic avant, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) emetrius D055A 0 KITA weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) APPT FROCK. DR 225 D055A WESTMINSTER MS ITA 110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BAYVIEW Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 13Alto STELLA FUNERAL HOME CHTO. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HARTIEY MILLER 7527 has Ford , 154 lte , two 2/234 tella RO 23a. P. n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieuwe of Light) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) of Vital Records, P.O. Box 68760, attending physician as the b IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be EBSTRUCTUE 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Tes director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) completely filled in by the funeral 27. Manner of Dr ath 1 Latural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 5 Pending investigation s after death. 1 Yes 2 No Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) celler, 6569 N. CHALLET BALTIMERE, MD 6 Ary 32. Registrar's Signature 31. Date filed (Month. State 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

		Certificate of Death	Reg. No. 2004 35085
	Physician	Intilities Evision	2. Dete of Deeth Month Day Year
ţ.	/Medical	4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Loca	0 C7 3 15 200 4 9 10 P
1	Examiner	Genesis eldercare RANDALIST	TOWN BALTIMORE
	Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Yrs. 1 M 2 F 7. Age (In yrs. last birthday) 1 Yrs. 1 Months Days Hours Min. 1 Usuel Residence of Decedent	9. Birthplace (State or Foreign (Month, Dey, Year) 1 - 12 - 1912
	ylend	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Ba-f si	MD N/A BALTIMORE	1 ☑ Yes 2 □ No
	ifer death with the Mei r terms 23s or 28s-f si river must be notified Funeral Ofrector	10e. Street and Number 10f. Zip Code 2824 WOODBROOK AVENUE 21217	10g. Citizen of Whet Country?
21215-0020	orse by		Specify: BLACK
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	should be filed withind Mental Hygiene. I marked other than umatic event, train To Be Comp	17. Father's Neme (First, Middle, Last)	First, Middle, Maiden Surname)
yla	Ments Ments arkad arkad	HENRY PAGE MARY	Price
Maryland	d 2 sho th end 7 is m traum	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R STE. LODO 48 PAR-LA-VILLE	
	r Health tem 27 other tr	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	C ROAD HAMILTON, BERMUDA Date 20c. Location - City or Town, State
E O	~ ~ .	1 Surial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)	06-04 WOODLANN, MD
Baltimore,	pemit. Page Depertment of Important: If any Injury or ance.	21. Signature of Funarel Service Licensee 22. Name and Address of Facility VAUGHN C. GREEN	e FUNERAL SERVICES HTL PIKE BALTO.MD 21229
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or hear failure. List only one ceuse on each line.	respiratory errest, Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. SEVERE PERIPUERAL VASC Due to (or as a consequence of):	Onset and Death
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	executed in end iel-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse, (Disease or injury	
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	et the death ce d by the ettendi eteched for use Physician/	Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
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ō	F SE D	27. Menper of Death 28e. Date of Injury 28b. Time of 28c. Injury at 28c.	b 5 ☐ Residence 6 ☐ Other (Specify) d. Describe how injury occurred
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	Hospit 4 hour Funer tely fill	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and seven in the basis of exemination end/or investigation, in my opinion, death occurred and manner stated.	
	within 2 To the complet	29b. Signature end title of certifier 29c, License number	29d. Date signed (Month, Day, Yeer)
	- > P O	\$ 5 Suph HD \$ \$0053150	NOV 2nd 2004
	3	30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Shallon Name and Gupa Po Box 6303	NOV 2nd 2004 ELLICOTT CITY 404042
1	State	31. Date filed (Month, Day, Year) 32. Registrer's Signature	

Donald	E_{\bullet}	Ford	3rd.
RJD			1 _ For

State of Maryland / Department of Health and Mental Hygiene 0 01

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			1 - State Registrar		Cei	tificate of Deat	th	ritar riyg Re	g. No.	JL	35086
	Physic	ian	Decedent's Name (First, Middle,	•				Date of Deat	h Dav	Year	3. Time of Death
	/Med	ical	4a. Facility Name (If not institution,	Donald Eugene	Ford I			October	31, 20	004	0114A. M
	Exami	ner	Harbor Hospital	give street and number)		4b. City, Town, or Localid Baltimore	on of Death		4c. County		
	Funera		5. Social Security Number	6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Und	ler 24 Hrs. 8.	Date of Birth	N/		lace (State or Foreign
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	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ation					0d. Inside City Limits
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	>		1 First Avenue	9		21225			U.S.		
	er death v Itama 23s	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	as Decedent of Hispanic (Yes, specify Cuban, Mexic	Origin? (Specify can, Puerto Ric	Yes or No- an, elc.)	14. Race		an Indian,
36	hours after tural, or ita	by F	1 XNever Married 2 Marrie 3 Widowed 4 Divorced	d 1 Tes 2 No If Yes, Give Year or Dates:		☐ Yes 2 🔀 No Specia				Whi	
Maryland 21215-0036	72 hours "natural",	ted	15. Decedent's	Education	16a. Deced	ent's Usual Occupation		1	6b. Kind of Bus		
215	d within 72 h jiene. ir than "natu	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give I	ind of work done during m O NOT use retired)	ost of working				adily
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17	2 should be i and Mental i Is markad or raumatic eva	70	19a. Informant's Name/Relationshi	d Eugene Ford Jr o (Type, Print)		Address (Street and Num			Snowde		^
	alth au 27 is		Deborah Harris	,		st Avenue			aryland		
J.G	es 1 and 2 of Health filtem 27 i		20a. Method of Disposition	20b. P	face of Dispos	ition (Name of atory or other place)	Date		Oc. Location - C		
Ĕ	Page tment tant: It jury or		1 ∑ Burial 2 ☐ Cremation : `4 ☐ Donation 5 ☐ Other (Spe	I I LIGHTOVAL HOLD STATE	-	n Mem. Park	11/4/2	004 G	len Rur	nie.	Maryland
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	Center	22.	Name and Address of Fac 01 Ritchie H	Gonc	e Fune	ral Ser	vice	
68760,	eath certificate be executed with certificate be executed attending physicien and for use as the burial-transit	Medical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, the state of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence to one t	uence of):	inshot World	nds				Interval Between Onset and Death
O. Box	The law requires that the death certific ate has been signed by the attending p cage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 □E	ictopic pregnancy Other (specify)		Ar————————————————————————————————————	23d. Date Monti		/ Pay Year
<u>α</u>	s that ned b e deta	by Pr	Part II. Other significant condition	s contributing to death but not resu	ilting in the und	erlying cause given in Part	1.	23e. Did toba	cco use contrib	ute Io the	cause of death?
ord	w requires been signs should be	ted t	Blunt torce	Head sinjury	es			1 🗆 Yes	2 No 3	☐ Probat	oly 4 DUnknown
al Records,	i cian : The law ri certificate has be ector, page 2 sh	Completed						24a. Was an autopsy performe 1 Yes 2	d? prid	or to comp ath?	y findings available pletion of cause of ☐ No
Vital	Phyaiclan: this certificatal director, I	To Be	25. Was case referred to medical examiner? ↑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☑ 6	ER/Outpatient	Other	e of Death (Ch				
Jou			27. Manner of Death		28b. Time of	28c. Injury at Work?	lursing Home 28d.		injury occurred		
Sior	ttending Ph death. ctor: After th y the funeral	atio	1 Natural 5 Pending 2 Accident investigat	ion 10/3/104	12:40 K	Work? 1 ☐ Yes 2 ☐	(No Sid	hier t w	as sho	+	
Division		Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, elc. (Specily,	me, farm, stree LWEUJ	t, factory, office	,	o ation (Street) City or Town, S	الماليات	or Rural F D High	Route Number,
	To the Hospitel or Attending within 24 hours after death. To tha Funerel Diractor: Attei completely filled in by the fune	edical	29a. Certifier (Check only one) Check only one)	Physician: To the best of my know aminer: On the basis of examinati and manner stated.	vledge, death o	occurred al lhe time, dale a stigation, in my opinion, de	nd place, and d	lue to the sauce	20/2) 224 22-22	er as stat d due to th	ed. ne cause(s)
	To the To the Comp	M	29b. Signature and title of certifier			29c. License number			Date signed (/		
			Hamat 150	restall, mo		O.C.M.E.		O	ctober	31, 2	2004
ì	7)		30. Name and address of person when Pamela E	o completed cause of death (Item	23a) (Type, Pr	111 Penn St	reet, I	Baltimo	ore, Mai	rylan	d 21201
	Ch		31. Dale filed (Month, Day, Year)	32. Registrar's Signatu	ITAR						

Registrar

NOV 0 5 2004

			1- State of Maryland / Registrar	Department of Health and Me Certificate of Death	ental Hygier Reg. I	Z11114 351187
	Dhysisi	~-	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Evelyn Irene Fogle		October	30 2004 6:35A ^M
	Examir	ier	4a. Facility Name (If not institution, give street and number) Country Companions	4b. City, Town, or Location of Death	1	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b.	Taneytown irthday) If Under 1 Year If Under 24 Hrs. 8	8. Date of Birth	Carroll 9. Birthplace (State or Foreign
ы	Director		214-10-1006 ¹□M 2 ^M F 92	Yrs. Months Days Hours Min.	Month, Day, Yea	1912 Maryland
	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Toy	vn or Location		10d. Inside City Limits
	Maryli f sho	jo	Maryland Carroll	Taneytown		1 A Yes 2 No
	r 28a	rec	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	23e o	a D	111 Trevanion Rd.	21787		U.S.A.
	ar dea	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: White
9	72 hours after death with the Maryland natural', or items 23e or 28e-f show dical Examinat must be rodified at	ted		. Decedent's Usual Occupation	16b.	Kind of Business/Industry
21	within 7 ene. then "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	9	
121	filed w Hygier other th		17. Father's Name (First, Middle, Last)	Seamstress 18. Mother's Name ((Figure Addedule Admini	sewing factory
and	id be f ental k ked of	To Be	Paul Plunkert		nce Ellen	· · · · · · · · · · · · · · · · · · ·
Maryland 21215-0036	S should be filed withir and Mental Hygiene. Is marked other then burmatic event, the Mental the Me	-	19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street and Number or Rural I		
_	12 mg					, MD 21787
lore	Pages 1 nent of H int: If iter		1 Burial 2 □ Cremation 3 □ Removal from State cemete	of Disposition (Name of Day, crematory or other place)		Location - City or Town, State
Baltimore,	Pariti		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service Ligensee ✓ ✓ ✓ ✓	aul's Luth. Cem 11/2/2		iontown, MD
Ba	permit. Departn Importe eny inju		Carraine V. Xaikler	nut	tzler Fur ion Brid	neral Home ge, MD 21791
П			23a. Part1. Enter the disease, or complications that caesed the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or r	respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	enter whoen		/int-
	Examiner		One ty (or as a course unence	1 To Vascular	Over	al glass
		ner	Fecuantially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			- Inger
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	ced the		9 Zy
68760,	be ex sician burial		Due to (or as a consequence	oi).		
687		edical	d.			
Вох	eath certi attending I for use a	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	a 3□Ectopic pregnancy		23d. Date of delivery
O. E	The law requires that the death cert tie has been signed by the attending age 2 should be delached for use	Physiclan/M	in the past 12 months? 1	5 Other (specify)		Month Day Year
σ.	s that the dended by the a		Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
rds,	quires an sign uld be	ed by			1 🗆 Yes	2 No 3 Probably 4 □Unknown
Record	e law requ has been je 2 should	Completed			24a. Was an	24b. Were autopsy findings available
Ä		Com			autopsy performed? 1 ☐ Yes 2 Ø N	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (
of	Phys this ral dii	7	1		5 Residence	6 SOther (Specify)
lon	nding I th. : After s funer	atlon		njury Work? M 1 ☐ Yes 2 ☐ No	d. Describe now in	diry occurred
Division	ol or Attendii after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
	urs aft					
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the basis of examination are and manner stated.	a, death occurred at the time, date and place, and id/or investigation, in my opinion, death occurred	d due to the cause(at the time, date ar	(s) and manner as stated. and place, and due to the cause(s)
	To with To I	×	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
	5	1	30. Nam, and address of person who completed cause of death (Item 23a)	(Type, Print)	,	1111607
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	la Read, Westm	iske 11	D 21157
	Registr		NOV 0 5 2004 Server B	Sports		

State of Maryland / Department of Health and Mental Hygien 0 0 1, 35088 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Inas Fincham /Medical 10 3D-2004 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death ROSEDALE G. Sex Franklin HOSDITAL more 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🔀 F 78 Yrs. Director 413-38-9813 Usual Residence of Decedent Items 23a or 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2- No Middle River 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Control Court 21220 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Defense Contractor Elementary/Secondary (0-12) College (1-4or 5+) Hygiene 12 Assembly Worker ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F George William Troutman Ada Millie McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 ie any injury or other trau Mrs. Dolores Collins/Daughter 49 Taos Circle, Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State Nov 4 `4 ☐Donation 5 ☐ Other (Specify) Holly Hill Mem. Park Baltimore, MD 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives M00986 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ON /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) attending physicien Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Tes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate performed' 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this | Director: After this 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number D0057863 ețed cause of death (Item 23a) (Type, Print) η Dr. Hossein Arde Mali-acoc Franklin Square Drive-Baltimore, MD. 21237 31. Date filed (Month 32. Regis rar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 35089 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year Earnest E. Fowler NOVEMBER 1,200 4.46PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7/30/1923 **Funeral** 9. Birthplace (State or Foreign 1**X** M 2□ F Virginia Director Yrs. 81 224-24-5611 Usual Residence of Decedent Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show 10d. Inside City Limits treumatic event, the Medical Examiner riust be notified at Director MD N/A Baltimore 1 XYes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 or itams 23a 4406 Lasalle Avenue U.S.A. Funeral 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2ADNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7/ h and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Bobs Transport 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Fowler Bessie Lee Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Importent: If item 27 is any injury or other treu ODGs. M. Norma Fowler/Wife 4406 Lasalle Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Parkwood 11/6/04 Baltimore, Maryland 21. Signature of Fueral Selvice Ligensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 92 unknown /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physiclen: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 3 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To No Yes 2 □ No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred Natural 5 Pending death. after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0018230 then 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Proulevard, MD 21239 SHASH IDHARAN FALATHIC 31. Date filed (Month, Oay, Year) 32. Aegistrar's Signature State NOV 0 5 2004 Registrar 1000

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. 6. U U 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** William Edmond Garrigan , 200 NOVEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THEARE 19 HEAL ear If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 M 2 □ F Months 66 216-32-6248 Director June 17, 1938 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 27 is marked other than "netural", or items 23s or 28s-f show treumstic svent, the Medical Examitme must be invitiled at 1 X Yes 2 □ No Baltimore Maryland Directo lbe I 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 North Streeper Street United States 21224 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1956–1959 1 ☐ Never Married 2√7 Married Specify.White 3altimore, Maryland 21215-0036 1 Tyes 2 to No Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should ba filed within 72 ih and Mental Hygiene. 7 Is markad othar than "ne Elementary/Secondary (0-12) College (1-4or 5+) Steel Company Pipefitter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marianna Linz Joseph Francis Garrigan, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Departmant of Health and Important: If item 27 Is n 6506 Irwin Way, Elkridge, MD Ruth Garrigan/ Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Sacred Heart of Jesus 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) November 8 Dundalk, MD 2004 21. Senature Funeral Service License 22. Name and Address of Facility Rendon Funeral Home, P.A. any in /969 2818 East Baltimore St. Baltimore, Md 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Coronary UNKNOWN /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a nonsecuence of: burial-transit Due to (or as a consequence of): physician Physician/Medical the use as (YARKIGAN, WILLIAM IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🏖 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funerel C completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Henggeler 31. Date filed (Month, Day, Year) State NOV 0 5 2004 Registrar

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

29c. License number

20053312

29d. Date signed (Month, Day, Year)
November 2, 2004

Avenue, Baltimore, MD 21229

State of Maryland / Department of Health and Mental Hygiene 2 1- State Amend Items 23a per Dr., G837, Health Death Registrar 35091 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 29, 2004 **Physician HENRY** GARFINKEL 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3011 FALLSTAFF ROAD #505A BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonth | Days | Hours | Min. | DEC. 15, 1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 POLAND **Funeral** 1 M 2 □ F 80 214-30-6264 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 V Yes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 3011 FALLSTAFF ROAD #505A 21209 or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-College (1-4or 5+) CABINET MAKER FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GARFINKEL CHAYA GERSHONOVTTZ AARON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other traun 3011 FALLSTAFF ROAD #505A - BALTIMORE, MD 21209 TOBIE GARFINKEL / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 10/31/2004 RANDALLSTOWN, MD 14 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light Approximate Interval Between Onset and Death Immediate Cause (Final Priysician POYIL disease or condition resulting in death) /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as Examiner Pneumonia Acute. Cause. Enter Underlying Cause (Disease or injury use as the burial-transit signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical 5 yr's Parkinson Disease, Advanced IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 🗭 N 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only op-Be Hospital: Other: 1 Yes 20 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ► Residence 6 ☐ Other (Specify) within 24 hours after death.

To tha Funaral Diractor: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Mann of Death 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Certification: 1 En atural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident after death 6 Could not determine 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ourt Rl Ball m completed cause of death (Item 23a) (Type, Print) 363 5 Ger 31. Date filed (Month, Day, Year) 32, Registrar's Signature State NOV 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 35092 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year EMMA MAE GOSNELL October 26 2004 5:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster
If Under 1 Year | If Under 24 Hrs. Carroll Hospital Center Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🎞 F Yrs. Director 212-32-1547 Sept.14,191B Maryland Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at 1X Yes 2 □ No Director Maryland Carroll Westminster 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 810 David Ave 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "nationy or other traumatic event, Ite Magical Once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel E. Smith Addie C. Buckingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2833 Leaf Shade Dr., Ellicott City, MD

Date 20c, Location - City or Town State Howard H. Gosnell/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sams Creek Cem. 10/30/04 New Windsor, Md 21. Signature of Spheral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home attarine (310 Church St. New Windsor, Md. 23a. Part1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ysician and e burial-transit ATRIAL FIBRILLATION HRONIC Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical phys the t as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant allen 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown Completed OTHYROIDITY 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No KRACTURE 2 No 1 Yes the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 10 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending position from standing investigation 1 ☐ Yes 2 ☐ No 10/16/04 0800hrs 2 Accident 6 Could not be 28f. Location (Street and Number of Rural Rollie Number, City or Town, State) 810 David Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home within 24 hours Westminster, Md 21157 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number \$00 519 24 29b. Signature and I 29d. Date signed (Month, Day, Year) - 10-28-04 ma 2475 manues to 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) He Nort 1. Hen derson > West muter M.D Keineng Malcalmolive 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 5 2004 Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / Dep Registrer Ce	artment of Health and Mental H rtificate of Death	Hygien 2004 35093
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JAMES L. HILL	2. Date of Month OCTOR	Day Year
	Examin		4a. Facility Name (If not institution, give street and number) STAGNES HEALTHCARE	4b. City, Town, or Location of Death 'Baltimore	4c. County of Deeth
	Funeral Director		5. Social Security Number 6. Sex 103 M 2 F 7. Age (In yrs. last birthday, 2 F) 104 M 2 F	If Under 1 Year If Under 24 Hrs. 8. Date of (Month Month Days Hours Min.	Birth Day, Year) S 1924 9. Birthplace (State or Foreign Country)
	with the Maryland a or 28a-f show be notified at	tor	10a. State 10b. County 10c. City, Town or L	ocation TIMDEE	10d. Inside City Limits 1 √Yes 2 □ No
	ith with the 23a or 284 ust be not	Funeral Director	10e. Street and Number 349 GWYNN AVENUE	10f. Zip Code 21229	10g. Citizen of What Country? U.S.A.
36	or items	by Funer	11. Manital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc., 1 Tes 2 No Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: A A
215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
nd 2121	be filed withir tal Hygiene. d other then event, in e Mi	Be Com		DIPMENT OPERATOR 18. Mother's Name (First, Mic	CONSTRUCTION Idle, Maiden Sumame)
Maryland	2 should land Menister sumatic	ဥ	,	ing Address (Street and Number or Rural Route Nu	mber, City or Town, State, Zip Code)
		1000	1 2 Burial 2 Cremation 3 Hemoval from State	matory or other place)	20c. Location - City or Town, State LAURINBURG, NC.
Baltimore,	permit. Page Department of Important: If any injury or once.		1. Signature of Fune al Service License		JERAL SERVICES L PIKE BALTO. MD21220
	Pnysician	34	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or head allure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Corongry Arthur	ter the mode of dying, such as cardiac or respirator	y arrest, Approximate Interval Between Onset and Death 14 Months
	/Medical Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):	·	
8760,	cate be executed physician and the burial-transit	dicai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
Box 6	ne death certifi the attending I thed for use as	Physician/Medi		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P.O.	quires that the signed by and be detacted	b	Part II. Other significant conditions contributing to death but not resulting in the IHPERTENSION		id tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	. 42 CT	Completed		24a. V a p 1 🗆 Ye	utopsy prior to completion of cause of death?
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatie	26. Place of Death (Check or	lesidence 6 □Other (Specify)
ion of	ifter ing	ation; T	27. Manner of Death 1	The state of the s	be how injury occurred
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify)	City or	n (Street and Number or Rural Route Number, Town, State)
	ne Hosp n 24 hou he Fune bletely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to evestigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To the vithin comp	Ž	29b. Signature and title of certifier	29c. License number DS3 668	29d. Date signed (Month, Day, Year)
	\cap		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	110vela 2, 2004
	Sta	to.	Deborsh Som mo 900 31. Date filed (Month, Pay, Year) 32. Registrar's Signature	Caton Aue Battimo	ne, mo 21229
	Registi	_	West 0.5. 2004 Senera &	board	

toward, Milton

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 14 35094 Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Year 2:30AN Physician TR. 2004 HOWARD NILTON /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner BALTIMORE MANOR GENESIS CATON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 1 M 2□ F Yrs MARY/AND 215-78-1939 05/05/1960 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Marylend 10a State 10b. County or 28a-f show Yes 2□No traumatic event, the Medical Examiner must be notified a BALTIMORE **Funeral Director** MARYANA 10e. Street and Number 10g. Citizen of Whet Country? U.S.A 21216 3202 VICKERS 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No Never Merried 2 Married 1□Yes 2XNo ò Specify: BLACK Specify. Maryland 21215-0020 Ď 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CONSTRUCTION LABORER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nd Mentel HOWARD 2 MILTON Peges 1 end 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health end No 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, ME Shirley Howard / mother-20a. Method of Disposition 20th 3800 EGERTON other Department of Heal Important: If Item 2 any injury or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) DERRICK C. JONES 22. Name and Address of Facility The 24 Signature of Funeral Service License BALTO. Md. 21215 4611 PARK HIGHS. Are. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Physician uamous Cell Carcinoma Immediate Cause (Final disease or condition resulting in death) /Medical Examiner wence of): Physician/Medical Examiner url sician end buriel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Box 68760. Due to (or as a consequence of): the. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 ☐ Yes 2 No tL Yas ZJE NO To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1 X Natural s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Dire 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only

State Registrar one

29b. Signature and title of certified

onth, Day, Year) 31. Dete filed (Month, 32. Registrer's Signature

LHUU

29c. License number

eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

A () / H() 4 550/ 50 Ch ROVEN Blue 35 Baltimine 2(239)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 8:15p 1 November Antoinette Hopkins Jacqueline /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Washington 1201 Firth Of Lorne Circle Ft. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 O2 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) 1 ☐ M 2 💢 F Yrs. ΜĎ Director 50 213**-**60-7380 Usual Residence of Decedent 10d. Inside City Limits Maryland 10a. State 10c. City, Town or Location or 28a-f show treumatic event, the Medical Examinational be notified at 1⊈ Yes 2 No Director Boston MA NΑ 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 02119 items 23a 147 Centre Street Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural" or in any injury or other treumatic even. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oxfam America Human Resources Director 6yrs 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edith Jones John Hopkins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6206 Gator Place, Clinton, Md 20735 Edith Hopkins-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 11/6/04 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee March For Hot West 21215 4300 Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an has page 2 2 No certificate 1 Yes Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) S 1 S 2 No 2 ER/Outpatient 3 DOA 10 1 Tes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Home 27 Manner of Death Certification: After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: d in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I Medical Exeminer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Weltz 11/3/2004 D23743

Registrar

State

Greenway Ctr Dr., Greenbelt, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525

32. Registrar's Signature

Martin Weltz,

(Month, Day, Year)

NOV 0 5 2004

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene () () () 35096 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 6:30a M 31, 2004 October Louise Harrison Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Glen Arm Glen Meadows If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Sept 15,1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2**X** F Yrs. Maryland Director 215-18-9709 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. anti- if Item 27 is marked other than "naturel", or Items 23a or 28a-f show ury or other traumatic event, Item Medical Examinat must be inclifted at 1 ☐ Yes 2 No Director Glen Arm Maryland Baltimore 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 21057 USA 11630 Glen Arm Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 √Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 12 Social Security Admin. Management Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Μ. Hare Alice McKinney ျှ Vernon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3308 Glenmore Avenue, Baltimore, MD 21214 Mary L. Parron/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Department of Importent: if any injury or once. 1 4 Denation 5 ☐ Other (Specify) Lutherville, Maryland Saters Church Cemetery 11/4/04 21 Si nature di uneral Service di Tense 22. Name and Address of Facility Bryan W. Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OPD Immediate Cause (Final disease or condition resulting in death) D YISHRS Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fath, loading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Physician/Medicai the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow þ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð pe PERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed RONOR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Feath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospitel or Attending Pl 24 hours after death. e Funerel Director: After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completely fi

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

NOV 0 5 2004

29b. Signature and title of certific

(Check only one)

32. Registrar's Signature

29c. License number

(ROSS ROADS

		•	1 - For State Registrar	State of Maryland / Dep	eartment of Health and I		ne not	35097
	Physici /Medic Examin	al.	Decedent's Name (First, Middle, Last) FRANCIS FRANK H 4a. Facility Name (If not institution, give street) CTELLA MARIS		4b. City, Town, or Location of Death	NOV. 3	Day Year	3. Time of Death 5:25 p ^M
	Funeral Director		STELLA MARIS 5. Social Security Number 212-09-5269 Usual Residence of Decedent	7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Ye 6/28/16		KL blace (State or Foreign try) (LAND
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If I tem 27 is marked other than "natural", or Itams 23s or 28e-f show or other traumatic event, the Medical Exaltrinar must be notified at or other traumatic event, the Medical Exaltrinar must be notified at	Funeral Director	10a. State 10b. County MD N/A 10e. Street and Number 2821 HUDSON STR		I MORE 10f. Zip Code 21224	10g.	Citizen of What Cour	lod. Inside City Limits 1
020	ours after deatl	by	11. Marital Status 12 1 Never Married 2 Married 3 Nover 4 Divorced	Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerting Yes 2 № No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu ant, Itte Mudical	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	edent's Usual Occupation ended of work done during most of work DO NOT use retired) HANICAL SUPERVI	SOR AM	ERICAN	
aryiana	shoutd be file nd Menta! Hy s marked oth umatic evant	To Be	17. Father's Name (First, Middle, Last) JOSPEH L. HAS 19a. Informant's Name/Relationship (Type	101 701	18. Mother's Nan		CANOPACKI	
lore, Ma	iges 1 and 2: it of Health ar If Item 27 is or other trau		MRS. SHARON GILR 20a. Method of Disposition 1 Warrial 2 Cremation 3 Ren	20b. Place of Disp noval from State SACRED on	HEAR Ther (O4Ce)	Date 20c	. Location - City or To	own, State
Baltimore,	permil. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licence		EMETERY : 117 ACDOROWSKIFAFUNE 201 DUNDALK AVE	RAL HOME		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. Do not elecause on each line. GASTRIC ADENOCAR Due to (or as a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death
/60,	te be executed ysician and te burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
O. Box 68	The law requires that the death certificate to has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
Records, P.	w requires that i been signed by should be deta	by	Part II. Other significant conditions contri	buting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
Vital Rec		e Completed	25. Was case referred to medical		26 Place of Day	24a. Was an autopsy performed 1 Yes 2 X	? prior to co	psy findings available mpletion of cause of
Division of Vi	anding Physiath. or: After this ne funeral di	Certification; To B	eyaminer?	spital: 1	ont 3 DOA Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No	ome 5 Residence 28d. Describe how in	njury occurred and Number or Rura	1001101
Ö	Hospit 4 hour Funera ely fille	edical Cert	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	building, etc. (Specify) ilan: To the best of my knowledge, der r: On the basis of examination and/or	ath occurred at the time, date and place	City or Town, Si	e(s) and manner as s	tated. the cause(s)
ł	. 12	Med	29b. Signature and title of certifier	and manner stated.	29c. License number D4372J	29d.	Date signed (Month,	Day, Year)
	St	ate	30. Name and address of person who com DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)		LLEY RD. TIMONIUM	I, MD 21093	989 35	

DHMH 17 Rev 1/2001

NOVEMBER 3, 2004

FRANCIS HASKINS

ORIGINAL

			1 - For State Registrar	State of Mary		artment of H ertificate of L			/	35098
	Physici	an	Decedent's Name (First, Middle, Last	" 110-	100	7.1.1.00.1.0	7-	Reg. N 2. Date of Death Month , D	ev Voor	3. Time of Death
	/Medic Examin	al.	4a. Facility Name (If not institution, give	street and number)	ige .	4b. City, Town, or	Location of Death	vovember	2, 2004 c. County of Death	2:58 PM
	Examili	ÇI	Bon Secours	Hosptel	2	By Itin	we Mar	rland	N	/A
	Funeral Director		5. Social Security Number 3.48-74-1663 Usual Residence of Decedent	7. Age (In	yrs last birthday	Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Yea)EC-03,19	9. Birthp Court 42 Sout	lace (State or Foreign http) AROLINA
	aryland show	<u>.</u>	10a. State 10b. County	100	c. City, Town or I	. 0		1	1	Od. Inside City Limits
	the Ma 28a-f	Director	MAKYLAND N 10e. Street and Number	/A		10f. Zip Code	THORE		Citizen of What Cour	1 MYes 2 No
	23a or		1211 N. GI	LMOR S	TREET		2/2/7		USA	1
396	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Itams 23a or 28a-1 show event, it is Medical Exertimer, untile be healthed at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	in U.S. 13	-	ispanic Origin? (Spec n, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Americ Black, White, Specify:	
2-0	72 hor	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	/Giv	edent's Usual Occupa	during most of working	16b.	Kind of Business/Ind	dustry
d 21215-0036	filed within Hygiene. Ither than *	Completed	Elementary/Secondary (0-12) 12 HGRADE 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		DO NOT use retired) <u>L(TEACHER's</u> 18. Mother's Name (Public Se Hoos
Maryland		To Be	WILLIAM	1+	ODGE		EMM	4	NELS	ON
Mary	12 shi h and 7 is m Iraum		19a. Informant's Name/Relationship (7		1 / -		and Number or Rural	-	•	
	1 an Heall am 2 ther		ANDRETTA MILLEL-E	2	Ob. Place of Disc	The second secon	OB Da		O. MD. o Location - City or To	
Baltimore,	Pag nent int: I		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)	KING M	EM. PAR	K 11-0	6-04 W	DODLAWA	MARYLAND
Bal	permit. Pac Department Important: any injury once.		21. Signature of Funeral Service Licens	N. Wille	ans	22. Name and Addres	S of Facility BRO	NAVE.	FUNERA BALTO, M.	D. 21217
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the one cause on each line.	death. Do not e	nter the mode of dying	1.11	respiratory arrest,	4.	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a co		7.4000	arone	1 gret	16~	
П	Examiner	er	Sequentially list conditions if any, leading to immediate	b Due to (or as a co	ensequence of):					
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
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.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	ny Day Year
<u>α</u>	uires that t signed by ild be detai	by	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the	underlying cause give	en in Part I.	23e. Did tobacco	use contribute to the	ably 4 Unknown
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/ital		BeC	25. Was case referred to medical examiner?	Boxs	2001	5	26. Place of Death (1 Yes 2 N	lo 1 Yes	2LIN0
of	Phys this ral dii	ပ္	1 Yes 2 No	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpation		4 Nursing Home	5 Residence	6 ☐ Other (Specify	')
ion	Attanding I or death. actor: After by the funer	ation	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation		ar) Injury	Work	(? Yes 2 □ No	a. 2000/100 /100 /110	ary occurred	
Division	taf or Atters after de al Diracto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Luilding, etc. (S	At home, farm, s Specify)	treet, factory, office	28	f. Location (Street a City or Town, Sta	and Number or Rura te)	l Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edicai	one) Medical Exam	ysiciant To the best of miner: On the basis of exa and manner stated.	y knowledge, daa amination and/or i	nvestigation, in my op	pinion, death occurred	at the time, date a	nd place, and due to	the cause(s)
	With	Σ	29b. Signature and title of certifier	- AHO- (DL	29c. License			ate signed (Month, I	
1			30. Name and address of person who of	completed cause of death	(Item 23a) (Type	Print)	, 20008	1	UVE MUEL	22004
			Maurice Ke. 31. Date filed (Month, Day, Year)	d Son See	-			Bilton	Street -	11233
	Sta Registi		NOV 0 5 2		يم مس	Sport	hal .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35099 Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician JANET Α. HARRTS 2141PM NOVEMBER 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Med. Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 3. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 11/18/1928 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2€E 75 50-22-2957 Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. item 27 Is marked other then "natural", or Items 23e or 28e-f show other traumatic avent, the Medical Examination at the multified at Cardiff XXYes 2 No MD Harford Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21160 USA 1631 B Main St Completed by Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □ Yes 2 🛣 💢 o If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2XXI Specify: 3 X Modowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Services Community volunteer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Biermann Margaret A. Bruckner R. Alfred Pages 1 and 2 should daught eith. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LTC Kelsey Harris-Smith-PSC 77, DTRO-M, APO AE 09721 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ō Department of Important: If it any injury or o 1 ☐ Burial 2 XX € emation 3 ☐ Removal from State 11/4/2004 Eagle Crematory Leola, PA * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Harkins Address of Facility Funeral Home, 600 Main St. Delta. A1. Easer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. PA 17314 Delta, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical ANCER WITH METASTASIS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 93st (Sato Midolivers) 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 🗷 No 3 Probably 4 ☐Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No certificate has 1 ☐ Yes 2 PNo Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 🔀 No this 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After t Injury 5 Pending investigation 1 X Natural 1 Tyes 2 No death. 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, or Attanding after death. filled in by the

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral C

Medical

Registrar

29b. Signature and title of certifier

M 17.

29c. License number 2 3/854

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 11/02/2004

6028. ATWOOD RD#106 SELAIR MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA, MO

31. Date filed (Month, Day, Year)

NOV 0 5 2994

29a. Certifier

(Check only one)

32. Registrar's Signature

		•	State of Maryland / Department of Health a State of Maryland / Department of Health a Certificate of Death	nd Menta	l Hygien Rag. N	711111	35100						
	Physicia		1. Decedent's Name (First, Middle, Last) Joseph G. Holter	Mor	of Death	2004 Year	3. Time of Death 2:40 A M						
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Towson	f Death		County of Dea Baltimon							
	Funeral Director		5. Social Security Number 6. Sex 12XM 2 F 63 F 7. Age (In yrs. last birthday) 15 Under 1 Year 15 Under 2 Hours 1 12XM 2 F 63 F 7. Age (In yrs. last birthday) 15 Under 1 Year 1 Year 15 Under 1 Year 1 Y	Min. 8. Date (Moo	of Birth orth, Day, Yea 15,194	9. Bin Co Mai	hplace (State or Foreign ountry) Cyland						
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore White Marsh										
	with the	Direc	10e. Street and Number 101. Zip Code 21162		10g. (Citizen of What Co	puntry?						
36	irs after death	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 1 Yes 2 No Specify:	in? (Specify Ye., Puerto Rican, e	s or No- etc.)	14. Race - Ame Black, Whit Specify: W							
1215-00	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inspertment of Health and Mental Hyglene. Inspertment of Health and Mental Hyglene in Inspertment of Health and Mental Hyglene and injury or other traumatic event, the Medical Evertilist traisible rediffed at once.	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brakeman	of working		Kind of Business	/Industry						
land 2		To Be Co	(7) I dillot o reality (7) and (8) and (8)	r's Name <i>(First,</i> Anna Sc		en Sumame)							
AM, Mary	and 2 shou ealth and M n 27 Is mai		19a. Informant's Name/Relationship (Type, Print) Steven Holter (Son) 19b. Mailing Address (Street and Number 11340 Philadelphia	Rd. Whi	ite Mai	rsh, Md.	21162						
2:40AMaltimore, Mar	Pages 1 Iment of Hu tant: If iter jury or oth		Tablication of Santa (Specify)	Date 1/8/2004	g Bal		Maryland						
Bali	permit Depar Impor any in	0 1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Fune 1407 Old Eastern	n Avenue	e Essex	x, Md. 2							
)	Physician /Medical	60 N	23a. Fant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a brock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Approximate Interval Between Onset and Death									
JER 4,200, 68760, 5, ■	eate be executed hysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsubsort in Jury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
NOVEMISE S, P.O. Box 66	ne death certific the attending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	livery Day Year						
- 0,	luires that th n signed by Ild be detac	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23	e. Did tobacc		o the cause of death?						
LTER - Vital Record	icien: The law requir certificate has been s rector, page 2 should	Completed			a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of						
2 5	Phys	To Be	examiner? (thos:	1	Residence	6 x Other (Spenjury occurred	ocity) Hospice						
Division	the Hospitel or Attending hin 24 hours after death. the Funerel Director: After mpletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		cation (Street y or Town, St		ural Route Number,						
105	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and an analysis of examination and/or investigation, in my opinion, deat and manner stated.	d place, and due th occurred at th	e time, date a	and place, and du	e to the cause(s)						
	To t To t	M	29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number	25		Date signed (Mon	th, Day, Year)						
	10×1		W. A. Riley Towson	N. Charl		eet							
	Sta Regist	ate rar	31. Date filed (ANT), Van Ver) 2004 32. Registrar's Signature & Sports										

			For Stata Registrar	State of Mary		artment of H			ene 004	35101		
	Physici	an	Decedent's Name (First, Middle, Adam	Last)			Herget	2. Date of Death Month	Day Yeer	3. Time of Death		
	/Medio Examir		4a. Facility Name (If not institution,	give street and number)	· · · · · · · · · · · · · · · · · · ·		Location of Death	Ochaher	3 i Zaa y 4c. County of Deat			
1	LXaiiii	ici	The Johns +	tooking Ho	SPITAL	Baltin	more City	N/A				
	Funeral		5. Social Security Number		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birtl	hplace (State or Foreign untry)		
	Director		216-20-8743 Usual Residence of Decedent	78	Yrs.			Sept. 13		ryland		
	iand ow		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits		
	Many a-f sh	tor	Maryland F	altimore			Dunda	alk		1 ☐ Yes 2¾ΩNo		
	th the	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	untry?		
	ath wi	rai	4059 St. Augu				21222		United St			
	itams ref	Funerai	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Eve Armed Forces? 1 Yes 2(3)No	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the M-sical Exercitest rust be nuffied at	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Specify:	White		
21215-0036		Completed	15. Decedent' (Specify only highes		16a. Dece	dent's Usual Occupa	ation	ring 1	6b. Kind of Business/l			
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anc	d be family to do of	o Be	Benjamin Her					na Ports	alderi Sumame)			
Maryland	2 should be and Mental is marked o	은	19a. Informant's Name/Relationsh		City or Town, State, Z	lip Code)						
	and 2 alth a 127 is		Gloria Wetzel	/ Daughter	4059	9 St. Aug	ustine La	ane Dund	alk, Maryl	and 21222		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra ones.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation		20b. Place of Dispo cemetery, crei	osition (Name of matory or other plac		Date 2	0c. Location - City or	Town, State		
Ĕ	Pag ment ant: i		* 4 ☐ Donation 5 ☐ Other (Sp	ecity)	Hilltop	Service (Corp. 11,	/4/2004	Towson, Ma	ryland		
Salt	permit. Pa Departmer Important any injury		21. Signatury of Funeral Service L	icensee /	22 D1	2. Name and Address	s of Facility Funeral H	Home of D	undalk, In	ıC.		
=	0, L1 ≥ 6 0		220 Bart Folge the disease of	complications that caused the	. 79	22 Wise A	Ave. Dur	dalk. Ma	rvland 21	222 Approximate		
		ii.	23a. Part1. Enter the disease, or shock, or heart failure.				g, such as cardiac	or respiratory arres	51,	Interval Between Onset and Death		
	Pnysician /Medical		disease or condition resulting in death)	a Mesen Due to (or as a co		schemia				48 hours		
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687	ficate physis the	edicai		d								
Вох	eath certific attending p I for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		7F.+i			23d. Date of deli	very		
В.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at time		Ectopic pregnancy Other (specify)			Month	Day Year		
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Rec	has has	duo						autopsy	prior to c ed? death?	ompletion of cause of		
ta	ilcian: Th certificate rector, pag	e Co	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes 25	•	2 🗆 No		
<u>></u>	S 0 0	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Othe			ce 6 □Other (Spec	ify)		
u of			27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o		at	28d. Describe how				
siol	Attending Pr r death. ector: After th by the funeral	catic	2 Accident investig	ation			Yes 2 □ No					
Division	or At after d Direct in by	Certification:	4 Homicide determi	28e. Place of Injury building, etc. (S	At home, farm, str Specify)	reet, factory, office		28t. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 157 Certifying	Physician: To the best of m	v knowledge, deat	h occurred at the tim	e. date and place.	and due to the cau	ise(s) and manner as	stated		
	a Hos	edical	(Check only 2 Medical E	xaminer: On the basis of exa and manner stated	amination and/or in	vestigation, in my op	pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Month	, Day, Year)		
			Gnette Brown	mo, Pho.		RE5-	000	00	taber 31.	2004		
	3		30. Name and address of person v				in Wall	c Baltime	ere. Maryla	nd 21287		
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 5 2004	32. Registrar's	Signature	only						
	negist	ul	MOA & 9 5004	A STATE OF THE STA	Jes Sty	vocas						

		4	For State Registrar		State of M	•	epartment of Certificate of			eg. NZ 0	04	35102
	Physicia		1. Decedent's Name (F Joseph			Jones			2. Date of Dea	th Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If no	· · · · · · · · · · · · · · · · · · ·)	4b. City, Town,	or Location of Death	1 400 431750	4c. Coun	ty of Death	1,-2
			Stella M	laris-Mer			Balt:				I/A	
	Funeral Director		5. Social Security Numl 215–24–804	12	x 7. A M 2□ F	ge (In yrs. last birth	Months Days		(Month, Day	Year) 1926	9. Birthp Cour S.	place (State or Foreign ntry)
	and and	-	Usual Residence of De 10a. State 10	b. County		10c. City, Town	or Location				1	10d. Inside City Limits
	death with the Maryland Ims 23a or 28a-f show In ust be notified at	to	MD	N/A		Balt	imore					Yes 2□No
	ith the or 288	Director	10e. Street and Number	er			10f. Zip Code		1	0g. Citizen o	What Cou	ntry?
	23a c		2030 0	Cecil Ave				218			JSA	
36	after or Ita	by Funeral	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 □		12. Was Deceden Armed Forces 1 X Yes 2 I if Yes, Give Year or Dates	?]No	 Was Decedent of if Yes, specify Cu Yes 2√2 No 		pecify Yes or No- o Rican, etc.)	Spec	ace - Americ ack, White, ify:	
5-0036	72 hours "natural",	ted	15	. Decedent's Edu	ication	16a. [ecedent's Usual Occi Give kind of work don	upation	kina	16b. Kind of		
215	thin 7 e.	Completed	Elementary/Seconda	only highest grad ary (0-12)	College (1-4or	5+)	ife. DO NOT use retir	ed)	All ig	_		
2121		Con	7th	- A A A A A A A A A A A A A A A A A A A	N/A	Cc	ke Oven	19 Mothor's Non	ne (First, Middle,			Steel
and	d ta d	Be	17. Father's Name (Fin		168			Mary	Mil]		ine)	
Maryland	s 1 and 2 should be f Health and Mental itam 27 is marked o othar traumatic eve	2	19a. Informant's Name			19b.	Mailing Address (Stree				n, State, Zip	o Code)
Ma	D = 10 =		Pamela Lu			17	43 E. 35tl	n Street B	Baltimore	e, MD	2121	.8
<u>6</u>	s 1 and 2 if Health itam 27 othar tra		20a. Method of Dispos			comotoni	Disposition (Name of crematory or other p	ace)	Date	20c. Location	- City or To	own, State
E E	Pages nent of I int: If it: iry or o		1 🔀 Burial 2 🔲 0		Removal from Stat	9	L MEM. PI	1	3/2004	Laurel		MD
Baltimore,	permit. Pages 1 an Department of Heal Important: if itam 2 any injury or othar once.		21. Signature of Funer	ral Service Licens	(H) (H)		22. Name and Add	rose of Espility	ARCH FUNE	CRAL HO	ME-EA	AST 21202
			23a. Part1. Enter the	disease, or comp	lications that causine cause on each	ed the death. Do no						Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Fir disease or condition resulting in death)		a		rentil	Lan	ur "			Onset and Death
		ner	Sequentially list condi- it any, leading to immediate. Enter Underlyi Cause (Disease or inju-	tions,	b. Duato (or a	ti consequence is)				+	
	licate be executed physician and s the burial-transit	Examiner	Cause (Disease or inju- that initiated events resulting in death) Las		c Due to (or a	is a consequence of):					
8760,	ysiciar	edical E			d							
9		Med	IF FEMALE:	-			100			1	0.000	
P.O. Box	Attending Physician: The law requires that the death certif r death. sector: Alier this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pl in the past 12 mg 1 Yes 2 N 9 Unknown	regnant onths?		2 Fetal death at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	су		1	ate of deliv	ery Day Year
	quires that I in signed by uld be deta	by	Part II. Other significa	ant conditions co	entributing to death	but not resulting in	the underlying cause of	given in Part I.		bacco use co es 2 □ No		the cause of death?
Division of Vital Records,	The law re ate has bee page 2 sho	Completed							24a. Was a autop perfor	med2	D. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
/ita	ifcian: Th certificate rector, pag	Be	25. Was case referred examiner?		Hospital:			Mhan	ath (Check only or			
of \	ohysi this c	T	1 Yes 2 No			itient 2 ER/Out	atient 3 DOA	4 Nursing F	lome 5 Resid			who soice
on C	ding F	lon		5 Pending investigation	28a. Date of Ir (Month, I	Day Year)	ury W	ork? □Yes 2□No	20g. Describe ii	ow injury odd	unou	
isic	death death ctor:	ficat	0 00.0.04	6 Could not be determined	28e. Place of	njury - At home, far	n, street, factory, offic		28f. Location (S	treet and Nur	nber or Run	al Route Number,
Div	al or A after I Dira d in b	Certification:	4 Homicide	determined	building,	etc. (Specify)			City or Tow	m, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	ysician: To the be liner: On the basis and manner	of examination and	death occurred at the for investigation, in my	time, date and place opinion, death occu	and due to the curred at the time, o	cause(s) and r	manner as s	stated. to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and titl	le of certifier	~~	M	29c. Lice	nse number 10 8511		29d. Date sign	ned (Month)	Day, Year) 200 Y
1	\mathcal{O}_{X}		30. Name and addres	s of person who	complete ause o	f death (Item 23a) (ype, Print)	DI Rall	into	m d	717	002
	St	te	31. Date filed (Month,	Day, Year)		strar's Signature		Dell'	- CHICOYT	11 5 6/6		
1	Regist		NO	V 0 5 20	34 Sec.	sever p	& Sport					

DHMH 17 Rev 1/200

04-06950 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sha' Lyse Jones Amend Item 23ac27 per me 6838 Per 2000 14 Las 35103 For AI State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** JONES SHA'LYSE October 27, 2004 0022A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Saint Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Days Months Hours 214-67-7562 1 □ M 2 💢 F Yrs. MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic avant, the McCloal Examiner must be notified at 1 Yes 2 No MD BALTIMORE Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ö 21229 KUSSUTH Ш STREET Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 Tyes 2 XNo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiena. Important: If team 27 is marked other than "na any Injury or other traumatic ava-". Elementary/Secondary (0-12) College (1-4 or 5+) NIA N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SHANG TY'NEL JONES ALICIA MICHELLE CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALICIA M. JONES/MOTHER 111 S. KOSSUTH STREET BALTIMORE, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Conation 5 □ Other (Specify) RANDALLSTOWN, MD 11.01.04 KING PARK 22, Name and Address of Facility VAUCHN C. GREENC FUNCTAL SERVICED 5/5/ BALTIMURE NATIONAL PIKE BALTO, MD 21229 ure of Huneral Service Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to rheart failure. List only one cause on each line. 23a. Par Enter the diseas shork, or heart failure. Approximate Interval Between Onset and Death Immedia e Cause (Final diseas or condition resulting in death) Complications of hypoxic-ischemic encephalopathy Prysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any cause immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day for 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Fo the Hospital or Attanding Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ₩ Yes 2 R/Outpatient 3 DOA 2 2 🗌 No 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation after death.

Director: Ald in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little O.C.M.E. October 27, 2004

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

5 2004

30. Name and address of person who completed chuse of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

		1	For State Registrar	State of Ma	ryland / Depa. <i>Cel</i>	artment of He rtificate of L			ene a. No.	
			Decedent's Name (First, Middle, Last	rt)				2. Date of Death Month		3. Time of Death
	Physicia /Medic	al -		inski				NOVEME	ER Z ZC	104 18 28 AW
	Examin	er	ta. Facility Name (If not institution, give Upper Chesapeake		ampus	4b. City, Town, or	Location of Death Air		4c. County of De.	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	0.8	inthplace (State or Foreign
	Director	_	212-10-17/6	∑ M 2□F	88 Yrs.	Months Days	Hours Mill.	(Month, Day,)	1915 M	aryland
	land bw	J-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Harford			Bel Air				1 Yes 2 No
	ith the		10e. Street and Number		-	10f. Zip Code	24.04.4	10	g. Citizen of What C	
	eath w	erai	108 E. Ring Fac		ver in U.S. 13.	Was Decedent of Hi	21014	cify Yes or No-	U.S.A	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any figury or other traumatic event, the Medical Exercit er mast be notified at once.	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	0	If Yes, specify Cubar 1 ☐ Yes 2 🕱 No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	lićan, etc.)	Specify: (
21215-0036		Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of workin	9	6b. Kind of Busines	s/Industry
121	filed within Hygiene. other than "	mpi	Elementary/Secondary (0-12) 7th Grade	College (1-4or 5	+)	cionary En		I	Domino Su	gar Co.
	il Hygie other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M.	aiden Sumame)	
ylar	ould be Mental Markad c	To	Andrew Jasin				Anna	Smul		77.0-4-1
Maryland	d 2 sho th and 7 is ma traum		19a. Informant's Name/Relationship (Mrs. CaroLyn Mona,				and Number or Rural actoru Rd			21014
	s 1 and 2 of Health item 27 othar tra		20a. Method of Disposition		20b Place of Dispo	J-0-0000	Da		Oc. Location - City of	or Town, State
imo	Pages Iment of h tant: If ite		1 ☐ Burial 2 🗖 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Permoval from State y)	Bayview (Crematory	11/6/			Maryland
Baltimore,	permit. Page Department of Important: If any injury of otice.		21. Signature of Funeral Service Licer	vieler	_ 9	705 Belai	r Rd., Ba	etimore,	MD 2123	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not en	ter the mode of dying	g, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):	AITO,	XEMIA			50W2
ľ	Examiner			bue to (or as	a consequence cry.	PNEU	AINDM			ZVAQS
T.	p #	iner	Sequentially list conditions, if any, leading to instruct cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	05 200	MON)A ENT)A			VEARS
1.	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	DEIAN	ENTIA			YEARS
68760,	ficate be execut g physician and as the burial-trat	edicai E		_ d						
			IF FEMALE:				-,		-	
O. Box	The law requires that the death certifule has been signed by the attending tage 2 should be detached for use a	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	delivery Day Year
ِ مـٰ	res that the de signed by the a be detached i	۵.	Part II. Other significant conditions		•		5	23e. Did toba	acco use contribute	to the cause of death?
ords	w require been sig should b	ted t	HYPERTENSION	/	ANEURY	,	NIEN	1 Tes		Probably 4 Inknown
Division of Vital Records,		Completed by	PROSTATIC HYP	ERTROPH	Y, DEME	ENTIA		24a. Was an autopsy perform	prior t	
Vita	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	int 3□ DOA Oth	26. Place of Death er: 4 Nursing Hon	f	nce 6 Other (S	Decify)
of	g Phys er this veral dii	-	27. Manner of Death	28a. Date of Inju (Month, Da			The second secon		w injury occurred	330119)
sion	uttending I death. ctor: After y the funer	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	n		M 1	Yes 2 □ No	206 1		Dural Cauta Musika
DIVİ	or Att after d Direct I in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	200. Flace of III	ury - At home, farm, s c. (Specify)	treet, factory, office	4	City or Town,	, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier Certifying Pl	nysicien: To the best miner: On the basis o and manner st	f examination and/or i	th occurred at the tinnvestigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and manner ite and place, and d	as stated. lue to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	. ^		29c. Licens	_		d. Date signed (Mo	
			NA 11/10	yre by	QNE_	1 '	59435		NOVEMBE	2 2, 2004
	6+1		30. Name and address of person who	500	UPPER	CHESAF	EAVE	BEZA	WR M	21014
	St Regist	ate rar	31. Date filed (Month, Day, Year)		ar's Signature	Sporker	/			

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11/2/04

#427372

			1 - For State Registrar	State of Maryland / D	Department of Health and Certificate of Death	Mental Hygier		35105
	Physicia		1. Decedent's Name (First, Middle, Last	Tohnson		2. Date of Death Month NOVEM 02 C	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat		4c. County of Death	
	Funeral		5. Social Security Number 6.99	nes HEAUTHO	thday) If Under 1 Year If Under 24 Hrs	8 Date of Birth	9. Birth	place (State or Foreign
	Director		251-46-9761 1E	IM 200 F 91	Yrs. Months Days Hours Min.	March 30	1913 Sou	th Carolina
	nyland how		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	the Ma 28a-f s	ecto	Nary and NA	Ba	1 timore	100	Citizen of What Cou	1 Yes 2 □ No
	th with 23a or	ai Di	902 N. Wood	lington Rd.	21229		US	A
	ter dea ritems	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White	
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23s or 28s-f show ont, the Medical Examinating Let indiffed at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give / Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	ack
212-(nin 72 t n "nati Medica	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. e completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo. life, DO NOT use retired)		. Kind of Business/Ir	ndustry
12121	ited wit Tygiene ther the nt, the	Com	17. Father's Name (First, Middle, Last)		Homemaker 18 Mother's Nau	ne (First, Middle, Maid	Own ten Sumame)	Home
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be indiffied at any injury or other treumatic event, the Medical Examinat must be indiffied at any injury or other treumatic event, the Medical Examinat must be indiffied at any injury or other treumatic event.	To Be	Clarence	Williams	Bell	e Wil	liams	
Mary	d 2 sho th and I the me treume		19a. Informant's Name/Relationship (7)	рө, Print) 19b.	. Mailing Address (Street and Number or Ro	iral Route Number, Cit	y or Town, State, Zi	() () () () () () () () () ()
	es 1 an of Heal fitem 2 r other		20a. Method of Disposition 1	l comotos	Disposition (Name of y, crematory or other place)	Date 20c.	Location - City or T	own, State
altimore,	it. Pag intment injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	IVIT.	22. Name and Address of Facility	2004	ensdo	wne, Md
Ba	Depz Impo any i	9	Joseph	L. Kuss	Joseph L. Russ 2222 W. North A	Funeral Funeral F	tome to Md. &	21216
			23a. Part I. Enter the disease, or comp shook, or heart failure. List only o Immediate Cause (Final	ications that caused the death. Do r	not enter the mode of dying, such as cardia	or respiratory arrest,		Approximate Interval Between Onset and Death
I	Pnysician /Medical		disease or condition resulting in death)	aDue to (or as a consequence	of):			Thorn
	Examiner	Ŀ	Sequentially list conditions, if any, leading to immediate	b	of):			
	scuted ind transit	Examiner	cause. Enter Underlying Cause (Cls. ase or injury that initiated events resulting in death) Last	c				
68760,	death c∉rtificate be executed e attending physician and od for use as the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a consequence of	ot):			
	ertificat Ing phy e as th		IF FEMALE:					
. Box	that the death certified by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	rery Day Year
P.0.	that the ed by ti detache		9 ☐ Unknown Part II. Other significant conditions co		the underlying cause given in Part I,	23e. Did tobaco	to use contribute to t	the cause of death?
rds,	The law requires that the site has been signed by the bage 2 should be detached.	ed by	Certacalar			1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
3ecc	e law re has be je 2 sho	Completed	Hyperterson			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
ita	ian: Th rtificate stor, pag	0	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 ☐		2 □ No
of Vital Records,	Physici this ce ral direc	: To B	examiner? 1 Yes 2 No 27. Manner of Death		tpatient 3 DOA Other: 4 Nursing Firme of 28c. Injury at	lome 5 Residence		fy)
ion	ittending death. ctor: After y the fune	ation	1 ☐ Natural 5 ☐ Pending investigation		njury Work? M 1 Yes 2 No	200. 20020 110.11	nary obsarrad	
Division	l or Atto after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical C	29a. Certifier 1 Cortifying Phy (Check only one) 2 Medical Exam	sician: To the best of my knowledge iner: On the basis of examination and manner stated.	s, death occurred at the time, date and place d/or investigation, in my opinion, death occurred.	, and due to the cause irred at the time, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and little of certifier		29c. License number	29d. I	Date signed (Month,	Day, Year)
			30. Name and address of person who c	ompleted cause of death (Item 22a)	B65848998	No	umbir	7, 20cy
			Rebit Grune (d	mi) Stagner	Hospitel 900 Conton	Avine B	16/hora	21229
	Sta Registi		31. Date filed (Month NO Year 5	2004 32. Registrar's Signature	13 sparks			

ACBERTA Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 35106 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JAMES NOVEMBER Year **Physician** MANCHE 2.00 PM 2004 /Medical 4b. City, Town, or Location of Death

BATI MORE 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner KITCHIE HOSPICE 8. Date of Birth Month Day, Kear) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 218.28.1512 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f shows the control of th 1 Yes 2 □ No ALTIMORE Director MD10g. Citizen of What Country? 10e. Street and Number 21217 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Caban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian treumetic event, the Modical Examiner of Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify 3 Widowed 4 □ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DRIVATE DOMESTIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BOND MAUL EDWARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1933 MCCVUOH ST. DATT MORE, MD 2/2/17

ce of Disposition (Name of Date 20c. Location - City or Town, State) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is eny injury or other tree ODGE. SHEILAH S. WILLIAMS /DAVAHTER 20b. Place of Disposition (Name of 20a. Method of Disposition

1 Method of Disposition

3 Removal from State 11-12-04 OWINGS MILLS, MARYLAND `4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vanath C. GIREENE FUNELITE HOME 21. Signature of Funeral Service Licensee YORK ROAD BACTIMORE, MARY CANO 21212 Drugel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bnes Physician I noul wo Due to (or as a consequence of); /Medical **Examiner** Tancreatie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): attending physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 🗆 Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1850 6 1 ☐ Yes 2 ☒ No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

68760 Box P.O. Division of Vital Records,

or Attending within 24 hours a To the Funerel E

DHMH 17 Rev 1/2001

filled in by

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

NOV 0 5

29c. License number 1002290 29d. Date signed (Month, Day, Year)

faces, mis erson who completed cruse of death (Item 23a) (Type, Print)

E5 MD

32. Registrar's Signature

4 🗌 Homicide

29a. Certifier

			1 - For State Registrer	State of M	arylan		artment rtificate			and M		Reg. No	0 ls	3510	7
	Physicia	an	Decedent's Name (First, Middle, La W AN D A	st)		JO	HN50	ON			2. Date of De Month	Day	Year	3. Time of Deat	h" ² M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		•	_		Location o		NOVEMI		2004 ty of Death		
	Examin	CI		PITAL			A		MOF				N/A		
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	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or L	ocation							10d. Inside City Lin	nits
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hyglene. I Health and Menial Hyglene. I Health and Menial Hyglene. I Health and Menial Hyglene. I have seen as a marked other them "neturely, or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at	to	Maryland N/A		В	altimc	re							1 ½ Yes 2 □	No
	h the	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	What Cou	intry?	
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	er dea tems	nue	11. Marital Status	12. Was Decedent Armed Forces?	•	S. 13.	Was Decede If Yes, speci	ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.))- 14. Ra	ice - Amer ack, White	can Indian, , etc.	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		1 ☐ Yes 2	No No	Specify:			Spec	ity: Wh:	ite	
21215-0036	2 hou	ted t	15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupa	ation			16b. Kind of	Business/Ir	ndustry	
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and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last						18. Mothe			, Maiden Suma		: 1 - 1 - 1	
Maryland	should be not Mental marked o	2	Raymond 19a. Informant's Name/Relationship (19h Maili	ing Address	/Street s	and Numbe	The:		er, City or Tow		ilable)	
Na	id 2 shouth and 27 is muttern		Ronald E. Johns		sband									/land 212	225
	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition	,	20b. P	lace of Disperent	osition (Nam	e of	1		Date	20c. Location			
Ë	0 0		1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special			adowri				1/5,	/2004	Elkrid	lge, N	faryland	
Baltimore,	in part		21. Signature of Funeral Service Lice	nsee		/ 2	2. Name and	Addres	s of Facilit	y Go	nce Fur	neral Se			
<u> </u>	Dep Imp eny		& Inna M	Inamer	en		001 Ri			ghwa	y Ba:	ltimore		yland 212	225
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	/Medical Examiner		Tooling in doubly	Due to (or as	a conseq	uence of):								3 DA116	5
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseq	uenca of).								3 price	
	sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С											
Ö,	e exerian ar		resulting in death) Last	Due to (or as	a conseq	uence of):									
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Box 6	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	Ideath 3	⊒Ectopic pre						ate of deliv	rery Day Year	
	he de / the a	ysic	1 ☐ Yes 2 M No 9 ☐ Unknown	4⊡Pregnant a 9⊡ Unknown	t time or a	eath 5	Other (spe	эспу)							
Records, P.O.	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to death t	. %	ulting in the (underlying ca		en in Part I.			tobacco use co Yes 2 □ No		the cause of death?	
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Vital	icien: Th certificate rector, pag	0	25. Was case referred to medical		111	0-		1200	26. Place	of Death	(Check only		10.163	22,110	
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sio	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		in a h		M		Yes 2 🗌		28f Location (Ctront and Alexa	that as Du	al Carrie Mumbas	
Division	or Al after of Direction by	Certification:	4 Homicide determined		tc. (Specif	ome, farm, st	reet, factory,	, опісе				wn, State)	iber or mur	al Route Number,	
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	8		30. Name and address of person who	completed cause of HARBOR	death (Iten	n 23a) (Type	, Print) 3001 5	300°	TH HI	ANO	VER51	LEET, L	BALTIN	NORE, HD	-5
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 5 2004	32. Regist		iture	bocks								

DHMH 17 Rev 1/2001

			For State Registrar		Stat	e of Ma	aryland /	Depa Ce	artmen rtificat	t of H	lealth a Death	and M	ental Hy	giene Reg. No	. • •	4	35108
	Physici	an	1. Decedent's Nam					2. Date Mor						te of Death onth Day Yeer 3. Time of Death			
	/Medic	al	STANA 4a. Facility Name (I		JAMES		HNSO	N	4h Cihu	Town	Location o	of Dooth	Month WERL		County of	COXF	222 PM
	Examin	er	4 par l	Resares	D 2 1	ecol	Center		Ro	0. 6	Tw	or Death		40.	Hand	Z D)
	Funeral		5. Social Security N	lumber	6. Sex 1 XM 2	7. Age	(In yrs. last		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 2/20/1	th V. Year)	(9	. Birthpla	ce (State or Foreign
	Director		218-40-88		ILAM ZL	, ,	29	Yrs.					2/20/1	945			MD
	yland how		10a. State	10b. County	_		10c. City, T	own or Lo	cation							10	d. Inside City Limits
	Ba-f st	ctor	MD	Harfo	rd 		Jo	ppa									1 ☐ Yes 2 No
	with th	Funeral Director	10e. Street and Nu						10f. Zip					10g. Cit	izen of Wha	at Counti	y?
	ns 230	erai	1610 Dug	an Dri		Decedent 6	ver in U.S.	13.		085	Ispanic Ori	gin? (Spe	cify Yes or No		U.S.		n Indian
ပ္	after d		1 Never Marr	ied 2 Marı		ed Forces? Yes 2 1 1 s, Give							cify Yes or No- Rican, etc.)		Black,	White, e	c.
003	urel', c	d by	3 🗆 Widowed			or Dates:	1969		1 🗌 Yes	2121 No	Specify:				Specify: V	/hite	9
15-	in 72 h	oiete		cify only highe	t's Education st grade comple			(Give	dent's Usua kind of wo DO NOT us	rk done d	durina mosi	t of worki	ng	16b. K	ind of Busir	iess/Indu	istry
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	12 should be filed within 72 hours after death with the Marylan n and Mental Hygiene. I le marked other then "naturel", or Items 23e or 28a-f show raumatic event, the Medical Explanar must be notified at	Be	17. Father's Name		Last)								(First, Middle,				
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Mai	s 1 and 2 should f Health and Mer item 27 le marke other traumatic		Theresa J.			()							21085	er, City o	r Town, Sta	ite, ∠ip ((ode)
ē,	ss 1 and 2 of Health item 27 other tra		20a. Method of Dis	position	·		20b. Place	of Dispo		ne of	7 7		ate	20c. Lo	ocation - Cit	y or Tow	n, State
imo	Page nent c		1X Burial 2 `4 □Donation		3 □Removal pacity)	from State			ley Me			1/5/	2004	Tim	onium	MD	
Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of	uneral Scrvice	Licensee								n/Rosedal roire MD 2		neral H	l one	
Г			23a. Part1. Enter t	he disease, or art failure. List	complications only one cause	that caused on each lin	the death. D	o not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory ar	rest,		1	Approximate nterval Between
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	at the deat by the att tached for	sicis	in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	□No	4 🗆 1		time of death		Other (sp						Month		ay Year
P.0	that the ed by detach		Part II. Other signi		i ons contributing	to death bu	ıt not resultin	a in the u	nderlyina c	ause give	en in Part I.		23e. Did to	obacco u	ise contribu	te to the	cause of death?
Records,	quires tha n signed ald be de	d by	Ca	roleer	nesofa	the,							1 □ Y	'es 2[_ No 3 [Probat	oly 4 Dunknown
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ion	Attending F r death. ector: After by the funera	atior	1 Natural 2 Accident	5 🗌 Pendir investi	ig	(Month, Day	Year)	Injury	М		<br Yes 2 ☐ I	No					
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۵	pitel c	1 1	29a, Certifier	1 Contituin	- Physician 7	to the best of	of my knowles			- 4 4 1 - 4 1 - 4							
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in the filled in	edical	(Check only one)	2X Medical	ng Physician: T Exeminer: On and	the basis of manner sta	examination	and/or in	vestigation,	at the tim , in my op	oinion, deal	d place, a th occurre	and due to the d ad at the time, o	date and	place, and	due to ti	ed. ne cause(s)
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•	Λ		Der	nors of	- Gulla	MA,	DIVE		<u>A</u>	0/4	-200	,		NOV	EMBE	R (204
	.7		30. Name and add	ress of persyn	VUKN	cause of de	ath (Item 23:	a) (Type,	5/8 /	HOLF	BIKD	AV	E BAL	0	Md	212	22
	Sta Registr		31. Date filed (Mor	107 0°5	2004	32. Registra	r's Signature	\$	40	W.K.	2						

Johnson, Stanley James & # 346753

State of Maryland / Department of Health and Mental Hygien 2004 35109 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Thomas Andrew King November 2004 4:45 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 122 W. Lanvale St. Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 13, 1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. Director 212-30-6684 72 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itema 23e or 28a-1 show any injury or other traumatic event. It a Madical Examines must be notified an once. 1 Yes 2 □ No Director Maruland N/ABaltimore. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 West Lanuale Street 21217 Completed by Funeral u. s. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1951-1955 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Railroad year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Francis King Helen Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Wallace (Niece) 630 Charles St. Avenue, Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛱 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 11/8/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myoundial infunction noun /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cunsuluence of): Examiner burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Dinbete 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1typer tension 24a. Was an autopsy performe 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After t 1 Natural 5 Pending 24 hours after death. Funaral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) vel) 243386 11.5.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Even Place Balkinon up 2/217 toward, Duniel 40 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar WOY 0 5 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Inpend 1em#23a, 27, perME, G838, 12/18/04 LT

706	50		Unpend 1em	State of M	ME,G838,12 aryland / Depa	/18/04 artment o	of Health a	and M	ental Hygi	ene o			
			For State Registrar				of Death			200	4	351	10
	Dhuniai		1. Decedent's Name (First, Middle, L						2. Date of Death Month	Day	Year	3. Time of D	eath
	Physici /Medi		Gary S. Kray						NOVEMBE	R 1, 20	04	5:37p	М
	Examir	er	4a. Facility Name (If not institution, g	ive street and number)		4b. Cily, Tow	vn, or Location	of Death		4c. County of			
-			HARFORD MEMORIAL 5. Social Security Number 6.		e (In yrs. last birthday)	HAVR If Under 1 Y	E DE GF		8. Date of Birth	HARI		lace (State or F	Foreign
2	Funeral Director		154-40-6927	1 X □M 2□F	53 Yrs.		ays Hours	Min.	July 25,	1951	New	lace (State or F htry) Jersey	r
			Usual Residence of Decedent		1		1						
	anylar show	ř	10a. State 10b. County	1	Havre d						1	0d. Inside City 1 ☐ Yes 2	
	the Marylar 28a-f show	ecto	Maryland Harfo	ora	navie u	10f. Zip Coo			100	g. Citizen of W	hat Cour		A
	th with 23e or	ī	700 Pulaski Hig	phway Apt-3	C	210			103	USA	nat oou		
	rurs after death with the Maryla at' or Items 23e or 28a-1 sho Exardrar must be mullious	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	1		igin? (Spe	cify Yes or No- Rican, etc.)	14. Race		an Indian,	
9	or Ite	y Fu	Never Married 2 ☐ Married	1 TXYes 2 ☐ I	10 1970		No Specify:		nican, etc.)	Specify:	white,		
Ş	72 hours "natural", adical Exe	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	1974								
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212	d with giene.	mo	Elementary/Secondary (0-12) 12	College (1-4or 5		aborer				Const	cuet:	ion	
2	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Exemples must be notified.	Be Completed	17. Father's Name (First, Middle, La.	st)					(First, Middle, Ma	aiden Sumame	9)		
<u> </u>	should that Ment	To	Steve Kraynick						ainsack				
Mar	d 2 sh th and 7 la m traum		19a. Informant's Name/Relationship	. ,, . ,					Route Number, (Code)	
<u>ق</u>	Heall Heall tem 2		Gail Keltos / Si	.ster	20b, Place of Dispo	sition (Name o	of !		New Je	CSEV UC Dc. Location - 0		wn, State	
9	Pages nent of I int: If it		1 ☐ Burial		Metro Cr	matory or other ematory		11/0	4/04 B	altimor	e, N	Marylan	d
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene, Important: If item 27 la marked other than "natur any injury or other traumatic evant, It e Madical once.		21 Signature of Funeral Service Lic	ensee	2'	Name and A	ddress of Eacilit	ty	f Mourel o	T			
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each li	d the death. Do not ent ne.	er the mode of	dying, such as	cardiac o	r respiratory arres	st,		Approximate Interval Betwe Onset and Dea	en
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		clerotic C	ardiova	scular	Dise	ase				
	Examiner			Due to (or as	a consequence of):								
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	ocuted nd transit	Examiner	that initiated events	c									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):								
× 287	physicate to physical street.	Physician/Medical		d									
Box 6	eath certific attending p for use as	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date	of delive	iry	
	ie death the atte	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ∐Live birth 4 ☐ Pregnant at 9 ☐ Unknown		Ectopic pregn Other <i>(specif</i>)				Mon	th	Day Yea	ar
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tal	iician: Th certificate rector, pag	Be Co	25. Was case referred to medical				26. Place	of Death	(Check only one)		Yes	2□ No	
Ž	Phyaici this cer al direc	To B	examiner? 1 XYes 2 □ No	Hospital:	ent 2K ER/Outpatier	it 3□ DOA	Other		ne 5 Residen		(Specify	")	
n of	ng l		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o y Year) Injury		Injury at Work?		8d. Describe how	injury occurre	d		
Division	ittandi death. stor: A / the fu	icati	2 Accident Investigat 3 Suicide 6 Could not	ha -	unt . At home farm et		1 Yes 2		8f. Location (Stre	et and Numbe	or Pura	I Pouto Numbo	
Σį	lor A after Dirac	ertif	4 Homicide determine	building, et	ury · At home, farm, str c. (Specify)	eet, ractory, on	IICO		City or Town,	State)	OI HUIA	noute Number	J _a
	To the Hospitel or Attano Mithin 24 hours after death Lo the Funeral Director: completely filled in by the	Medical Certification:	25a. Centiful 1	Physicians To the best aminer: On the basis o	of my knowledge, deat	occurred at the	ne time, date an	id place, a	nd dua to the cau	ss(s) and man	nor as st	ated.	
	To the H Mithin 24 Lo the Fl complete	Medi	one)	and manner st	ated.			OCCUITE					
	2 4 9	-	29b. Signature and title of certifier	A sh	o Wo	29C. LIC	cense number OCME			1. Date signed OVEMBE!	•		
	200		30. Name and address of person wh	o completed cause of c		Print)	JOHN		14	للتركير عدد		2001	
_	(S.		MARYSMOS				Street,	Balt	imore, N	Marylan	d 21	201	
	Sta Regist		31. Date filed (Month, Day, Year)		ar's Signature	Spork				_			
	1109131			1	/ /		_						

Emily Jazmin Lam Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 123a 27 28a f per ME G839 1/13/05 TT State of Maryland per ment of Health and Mental Hygiene 04-07061 RJ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** November 2004 03:44 A.M Emily Lam 2, Jazmin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) October 14,2004 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 19 Hours 1 ☐ M 2 💢 F 0 214-71-5334 Director MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23a or 28a-f shov digal Exprimer must be notified at 1 ☐ Yes 2XNo MD. Baltimore Dundalk Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 1712 Burnham Road USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 is markad othar than "natural", or Ital 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White traumatic avant, I'm Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A O 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dale J. Mc Donald Sara Lam 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i 1712 Burnham Road, Dundalk, MD. 21222 mother Sara Lam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) November Parkwood Cemetery 6,2004 Baltimore, MD. 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Connelly Funeral HOme Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 yeu s 23a. Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Sudden Unexplained Death In Infancy (SUDI) resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine nding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Sign. be t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 24a. Was an performed? Yes Yes 2 🗆 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 XYes 2 ☐ No 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of FindInjury 28d. Describe how injury occurred Certification: Child placed in suspended number of Rural oute Number, 28t. Location (Street and Number of Rural oute Number, City or Town, State) 1712 Burnham Rd 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No death. 2:00 a 11/02/04 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Dundalk, Baltimore County, MD Residence.

hours after deat inaral Director; within 24 hours a

To the Funaral I

completely filled

> State Registrar

Medical

29a. Certifier

29b. Signature and title of

30. Name and address

31. Date filed (Month, Day, Year) NOV 0 5 2004

certifie

completed cause

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

f death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

November 3, 2004

			1 - For State Registrar		artment of Health and Me	ental Hygien	2004 30112
	Physici	an	Decedent's Name (First, Middle, Last)		1 11 2	2. Date of Death	year 3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give stree	at and number)	4b. City, Town, or Location of Death	DUEMBER	ic. County of Death
			The Johns Hop!	7. Age (In yrs. last birthday)	BALLIMORE If Under 1 Year If Under 24 Hrs. 8	Days of Birth	O Bishel (Out of 5)
L	Funeral Director		214.50.4654 1MM		Months Days Hours Min.	Month, Day Yea	9. Birthplace (State or Foreign MARY LAND
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	A		10d. Inside City Limits
	72 hours after death with the Maryland neturel; or Items 23e or 28e-f show died Exactrout Een diffied	Director	10e, Street and Number	BAUTI		10- 6	1 Tyes 2 No
	th with 23e or 3	al Dir		ARM WAY	10f. Zip Code 21209	109.0	Citizen of What Country?
	Items	Funeral	11. Marital Status 12. \\ 1 □ Never Married 2 Married	Vas Decedent Ever in U.S. 13. V Armed Forces? 1 Deceded 13. V	Was Decedent of Hispanic Origin? (Speci f Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	urel', or	þ		f Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: DLACK
215-(nin 72 h n "netu	Completed	15. Decedent's Education (Specify only highest grade contents) Elementary/Secondary (0-12)	mpleted) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	,	Kind of Business/Industry
12121	filed within Hygiene. other then "		17. Father's Name (First, Middle, Last)	2 M	AL HANDLER 18. Mother's Name (i		s. Postar SERVICE
land	Mental Harked of	To Be	EMMANUEL (C. LUH	THEC		RUNER
Mary	2 shc and le m	ľ	19a. Informant's Name/Relationship (Type, 1	Print) 19b. Mailin	ng Address (Street and Number or Rural F	1 /1	
ď	es 1 and of Health fitem 27 r other tr		20a. Met/od of Disposition 1 Burial 2 Cremation 3 Remo	20b. Place of Dispo	sition (Name of Date natory or other place)	e 20c.	Location - City or Town, State
Baltimor	t. Pag tment tent: f		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	ARLINGTON	V.A. COMETERY 11.23	04 AR	UNGTON, VIRGINIA REENE FUNERAL HOME
Ba	permit. Departimport any inj		Vauxh	i Green 4	105 YORK ROAD	DAUTIMO	KE, MD 21212
Ü			23a. Part1. Enter the disease, or completation shock, or heart failure. List only one call the control of the Course (Figs.)	ons that caused the death. Do not entrause on each line.	er the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):			Imonth
	Examiner	ē	Sequentially list conditions, b	Chronic Lyn	phocytic Leukem	iia	Tyens
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	500 to (51 as a consequence siye			3
8760,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence of):			
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Box	eath certific attending p for use as	lan/N	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	t the d by the tached	Physician/Medical		Unknown	Journey (specify)		
	uires tha signed Id be del	by	Part II. Dther significant conditions contribu	ıting to death but not resulting in the ur	nderlying cause given in Part I.		use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown
Records,	sw request speed	Completed				24a. Was an	24b. Were autopsy findings available
al Re		Com				autopsy performed? 1 ☐ Yes 2 ☐ N	prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	ital:	26. Place of Death (0 t 3 □ DOA Other: 4 □ Nursing Home		6 ☐Other (Specify)
n of	ding Phys h. After this funeral di	lon: T	1 ☑Natural 5 ☐ Pending	8a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at 28c Work?	d. Describe how inju	
Division	or Attendia after death. Director: A in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	Be. Place of Injury - At home, farm, stre	M 1 Yes 2 No eet, factory, office 28f	. Location (Street a	nd Number or Rural Route Number,
Ö	urs after rel Dire		4 Horniciae	building, etc. (Specify)		City or Town, Star	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	(Check only 2 Medical Examiner:	 To the best of my knowledge, death On the basis of examination and/or invand manner stated. 	occurred at the time, date and place, and restigation, in my opinion, death occurred	d due to the cause(s at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the Comp	Ä	29b. Signature and title of certifier		29c. License number		ate signed (Month, Day, Year)
	00		30. Name and address of person who complete	eted cause of death (Item 23a) (Type. I	Print)	Nove	mber 1, 2004
	(1)		Erica Warlick	101 North Broadwo		ingland.	21231
-	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 2004	32. Registrar's Signature		J	
DH	MH 17 Rev 1/2	001	100 4 0 200	10	pour		Ut to

ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SALIM BAGHLI

NOV 0 5 2004

5601 LOCH RAVEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL

and manner stated.

32. Redistrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

ROULEVARD - BALTIMORE - MD - 21233

29d. Date signed (Month, Day, Year)

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NON

2004

			, roi	epartment of Health and Certificate of Death		ene 004	35114
	Physici	an	Decedent's Name (First, Middle, Last) Margaret S. Long		Date of Death Month	Day Year	
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	November	3 2004 4c. County of De	
	Examin	ięr ,	Anne Arundel Medical Center	Annapolis		Anne A	
	Funeral Director		210 07 1020	hday) If Under 1 Year If Under 24 Hr Months Days Hours Min		9. B 1907 Ma	rthplace (State or Foreign Country) aryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Mary -f sho	ţō	Maryland Howard Ellic	cott City			1 ☐ Yes 21 No
	or 28s	lrec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What C	Country?
	ath wi	ral	3365 A North Chatham Road	21042		U.S.	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, the Medical Evant of must be indiffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Tyes 22 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
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2	filed withir Hygiene. othar than ant, the M		12th 17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma	A.A. Ofc.	or Aging
Maryland	12 should be fi and Mental F is marked of reumatic aver	To Be	Harry Miller		rgaret Gib		
lary	2 should and Men is marks sumatic			Mailing Address (Street and Number or F	Rural Route Number, (City or Town, State,	· ·
	1 and 2 Health am 27 thar tr		Patricia Lynch-Warntz/Daughter 25	D94 Vance Drive M Disposition (Name of	t. Airy, M	Saryland 2	
nor	Pages nent of H int: If its iry or ot		K Burial 2 Cramation 3 Removal from State cemeter	y, crematory or other place)			
Baltimore,	구두막는		`4 □ Donation 5 □ Other (Specify) New Ca 21. Signature of Funeral Service Licensee	thedral Cemetery 11 22. Name and Address of Facility C	once Funer		
ä	Depar Impo any ir		> Jerome grammaenter)	4001 Ritchie Highw	ay Balti	imore, Ma:	ryland 21225
			23a. Part1. Enter the disease of complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardia	ac or respiratory arres	st,	Approximate Interval Between Onselland Death
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	ecuter and -transi	Examiner	that initiated events	è Syrdiome			days
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٥	ires that the signed by dispersed detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute (to the cause of death?
ords	w require been sig should b	ted k			1 ☐ Yes	2 □ No 3 □ P	robably 4 Gunknown
Il Records,		Completed			24a. Was an autopsy performe 1 \(\sum \) Yes 2 \(\sum \)	prior to	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Others	eath (Check only one)		
of	S S	To T	27 Manny of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at	Home 5 Residen		ecity)
ion	Attanding F r death. sctor: After by the funer	atlor	1 ✓ atural 5 ☐ Pending (Month, Day Year) In 2 ☐ Accident investigation	njury Work? M 1 ☐ Yes 2 ☐ No			
Division	after dea Diracto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fall building, etc. (Specify)	m, street, factory, office	28f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
Ω	pital o		Constitute of the state of the boat of the			- /->	
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.				
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Mon	th. Day, Year)
)			Hime J. Vairs MD	D53111		11/3/0	9
-	7		30. Nam a d addres of person who completed cause of death (Item 23a) (Dr. Hung Davis 2001 Medical Page	• • • • • • • • • • • • • • • • • • • •	Maryland	21403	
	Sta Registi		NOV 0 5 2004 32. Registrar's Signature	Sports			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

			For State Registrar	State	of Marylai		artment of H rtificate of L		nd Mental Hy	gien e () Reg. No.	04	35115)
			1. Decedent's Name (First, Midd	fle, Last)			1- 5111		2. Date of De Month	ath		3. Time of Death	_
	Physici /Medic		June Audrev Lind	sev					November	2, 2004	Year	7:00 A	М
	Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, or	Location of	Death	4c. Coun	ty of Death		
			1199 Hanson Road				Edgewood			Har	ford		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bin Min. (Month, Da		_	place (State or Foreig	gn
	Director		213-20-5775	1 □ M 2 □ F	80	Yrs.	Months Days	Hours	Min. 8. Date of Bin (Month, Da	1924	Mary	land	
	p ,		Usual Residence of Decedent		10- 0	. T							
	anyla shov	-	10a. State 10b. Count			ity, Town or Lo	cation					10d. Inside City Limit	
	8e-f	ctc		ltimore		Sparks						1 🗆 Yes 2 📈 N	0
	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	ath v		9 Glen Falls Path				21152			US/			
	er de Kema	Funeral	11. Marital Status	Armed F			Was Decedent of Hi f Yes, specify Cuba	spanic Origii n, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		ice - Americ ack, White,		
36	or or	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		2 No		1□Yes 2□ No	Specify:		Spec	^{ify.} ₩hite		
21215-0036	d within 72 hours after death with the Maryland jiene. r than "natural", or Ifems 23a or 28e-f show The Medical Examiner must be notified at	ed		nt's Education	Da163.	16a Decer	dent's Usual Occupa	ation		16b. Kind of I			
15	C 2 00	Completed	(Specify only high	est grade completed		(Give	kind of work done of DO NOT use retired	lurina most c	of working	TOD. KING OF	203111635/111	dustry	
12	within iene. than "	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)					l.loodbal		onton. Calan	_1
	Hyg the tr		17. Father's Name (First, Middle	, Last)		100	cher's Aide		s Name (First, Middle,			entary Schoo	Л.
an	d a b	To Be	H. Carroll Meade					Edna	Dillinger				
Maryland	d 2 should by the and Menta it and Menta it is marked traumatic events.	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street a		or Rural Route Numbe	er, City or Town	n. State. Zic	Code)	_
	C - N -		Vovin Lindon /Son			2000				27722	,	•	
Baltimore,	1 al Hea Bm Bm the		Kevin Lindsey/Son 20a. Method of Disposition		20b.	Place of Dispo	n Falls Pat sition (Name of	1	ks Marvland —	21152 20c. Location	- City or To	own, State	
OLL.			1 ☑ Buriał 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (1 State		natory or other place		./6/04	Deltima	uaa Maia	u land	
量			21. Signature of Funeral Service				emorial Par . Name and Addres	N ,		Baltimo	re mar	Araud	_
Ba	permit. Departr Importe any inju		Chiat	VIII IS	LIII L. F	IIIWII	eonard J. R		5305 Harfo C. Baltimore		2121	4	
	-		23a. Part1. Enter the disease, of	or complications that	caused the dea	th. Do not ent	er the mode of dying	, such as ca	ardiac or respiratory ar	rest,	2121	Approximate	
			shock, or heart failure. Lis Immediate Cause (Final	t only one cause on	each line.		ULAR					Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	-	NO DICU	V 1130	UNIC	nue 1	DEN (9 WEEK	5
	Examiner			RU	GHT	HEW!	DIETI	1 <	SECONDA L SECO,	(A)		9 war	ė.
	28 7	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec	quence of):	F V Call	7	SECONON	29	-	- CE	-5
16	uted d ansit	Examiner	Cause (Disease or injury	√ D:	1SPI+	KGIA	- CET	STRA	(SETO	WOAK	24	9 WEEK	4
,	execu n and ial-tra	Exa	that initiated events resulting in death) Last	c	(or as a consec	quence of):	1				-		_
68760,	icate be executed physician and s the burial-transit												
.89	9 4 9	edlcal				800				317 111	3		
Вох	eath certifi attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn					23d. Da	ate of delive	erv	
m	death a atte d for	cla	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Preg	birth 2 ☐ Feta nant at time of c		Ectopic pregnancy Other (specify)			М	onth	Day Year	
0	at the de by the a tached	ys	9 □ Unknown	9□ Unki	nown								
٥.	law requires that the death certif as been signed by the attending 2 should be detached for use a	by P	Part II. Other significant condit	ions contributing to	death but not res	sulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?	
g	quire; n sig nd blu		DEMENT	1 A-					1 🗆 Y	es 2 No	3 ☐ Prob	ably 4 □Unknown	า
S	w requir been si should	lete	ANEMIA	IRON.	DEPIC	1 FA	11		24a. Was a	an 24b.	Were auto	psy findings available	Α
Records,	The lav ate has page 2	Completed	ALMIA	1 RON. B12-1	Ton	10			autop perfor		prior to cor death?	npletion of cause of	
Vital	icien: T certificate ector, pa	o C	25. Was case referred to me ica	D(-J	EAC	NENC	y			2 No	1 🗆 Yes	2 □ No	
S		o Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	I CD/Outpation	Othe	-	f Death (Check only or			Assisted	-
of		\vdash	27. Manner of Death	28a, Date	of Injury	28b. Time of	28c. Injury Work		ing Home 5 Resid		her <i>(Specif</i> y rred	Living	-
O	ding P th. After funera	tlor	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Moi igation	nth, Day Year)	Injury		? ′es 2.⊡No					
Division	al or Attending after death. I Director: Afte d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury - At h	ome, farm, stre	eet, factory, office		28f. Location (S	treet and Num	ber or Rura	l Route Number.	_
Ö	in Sir de	erti	4 Homicide	build	ling, etc. (Speci	fy)			City or Tow	n, State)			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifyi	ng Physician: To th	e best of my kno	owledge, death	occurred at the time	e, date and p	place, and due to the c	ause(s) and m	anner as st	ated.	
	e Hc	edical	(Check only 2 Medica one)	Examiner: On the I	pasis of examination of the state of the sta	ation and/or inv	estigation, in my op	inion, death	occurred at the time, o	late and place,	and due to	the cause(s)	
	To th withir ro th comp	Me	29b. Signature and title of dertifu	- //	0		29c. License			29d. Date signe		-	
	. , , ,		> furfar	10 (. Van	ara	o H.	DOC	163	89 1	VOVEH	BER	2, 2001	1
•	_		30. Name and address of person	who completed cau	se of death (Iter	n 23a) (Tyne	Print)					1 7	=
	اعاً		PERFECTO	C. VKL	ARAD	r(.D.	1716 HA	PORD	ROAD SU	106	PAIL	570N. MI	2
	Sta	te	31. Date filed (Month, Day, Year		Registrar's Signa	ature	Long						

State of Maryland / Department of Health and Mental Hygien 2004 State Registrar AMEND ITEM #16b&20b PER G837 CP [tifficate of Peath Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Herbert McDonald October31,2004 **Physician** 45a /Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Joseph Richce Hospice If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** North carolina 1**⋈** M 2□ F Months Days Hours 47237 641) 239-56-4933 63 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "naturel", or items 23e or 28e-1 show other treumstic event, the Mcdical Examinat must be rediffied at Baltimore Md. 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1400 N.Fulton Ave. 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 34 ☐ No If Yes, Give Never Married 2☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:Black Completed by Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry IMPROVEMENT al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Home inprovement 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental Fishmarked of Herbery McDonald Sr. Edna Mae Gainey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1619 Riverwood Rd. Back River, Md. 21221 Lwanne Jackson item 27 20b. Place of Disposition (Name of cometer Page and or other place)
Druid Hill CEm. 20a. Method of Disposition 20c. Location - City or Town, State Department of himportant: If its any njury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 11/5/04 Pikeville, Md. Lunisyai Pervice Balto.Md. 22. Name and Address of Facility Miller's Metropolitan Chapel P.C. 22a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vente PLIN disease or condition resulting in death) /Medical Due to (or as a donsequence of): Examiner MUS to ce. Chillon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit death certificate be executed AIDS-Due to (or as a consequence.of): Division of Vital Records, P.O. Box 68760, Physician/Medical ENDOMRAIT IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other Specify 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide n 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3000 Ken M MICHASI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPICE TICHE 31. Date filed (Month, Day, Year) g 32. Registrar's Signature State Registrar NOV 0 5 2004

DHMH 17 Rev 1/2001

McDonald

State of Maryland / Department of Health and Mental Hygieney - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** November 1, 2004 David Michael McGreevy 2355 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Nov. 12, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F Yrs. 215-72-0032 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò filed within 72 hours after death with 205 Woodbine Court 21050 United States or itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 図 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 28 Married Specify: white 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "na any injury or other traumatic event, the Madia once. (Specify only highest grade completed) soap Elementary/Secondary (0-12) College (1-4or 5+) sulfonation operator manufacturer Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John M. McGreevy Evelyn R. Conrad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christine Ann McGreevy/wife 205 Woodbine Court, Forest Hill, Md. 21050 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gdns. 11/6/2004 Bel Air, Md. 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician MYCCHRDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 2 🗌 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funaral Dire Hospital 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air Mi) MI KARL SPECTOR ZCIY TOLIGATE RD 2. Registrar's Signature Registrar

"IcGreevy, Javid

		For State Registrer	State	of Marylan	-	artment of H		nd Mental Hygi	ene 200	4 35118
Physici		Decedent's Name (First, Middle Rosa Marot						2. Date of Death Month November	Day Ye	
/Medio Examir		4a. Facility Name (If not institution, Good Samarit	give street and nu			4b. City, Town, or	Ltimore	Death	4c. County of D	
Funeral Director		5. Social Security Number 215-05-4270	6. Sex 1 □ M 2 🂢 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24		9.	Birthplace (State or Foreign Country) Maryland
death with the Maryland ms 23a or 28a-f show rinust be notified at	Director		altimore	10c. Cit	ty, Town or Lo	Balt	timore			10d. Inside City Limits 1 ☐ Yes 2 ※ No
13-UU30 n 72 hours after death with the Maryla naturel, or Items 23s or 28s-1 show safe. Executed at some safe.	Funeral Dire	10e. Street and Number 9225 Bowline Ro 11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.		236 Ispanic Origin	1? (Specify Yes or No-		A. merican Indian,
IZID-UUSO within 72 hours after ane. then "naturel", or ite the Modic Execution	þ	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or I	2∭No ive		1□Yes 2风No	Specify:		Specify:	white
nd z z 3- be filed within 72 tal Hygiene. d other than "nal event, the Madic	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 6th Grade	t grade completed) (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired	during most of d)	f working	6b. Kind of Busine	Clothing
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Fe, IMal		19a. Informant's Name/Relationsh Marianna Haney 20a. Method of Disposition		20b. F	24 GX	Casshouse	Garth,	or Rural Route Number, Baltimore Date 2	•	nd 21236
Baltimol permit. Pages Department of Importent: If if any injury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Furer 1 ☐ erv. Sp.	ecify)	i State	st Holy	natory or other place I Redeeme P. Name and Addres I 705 Ropa	t 11	/5/2004 Schimunek F Baltimore	uneral Ho	omes
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ath certific trending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Fete inant at time of d	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
S, T	þ	Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I.			o to the cause of death? Probably 4
The law ate has b	Completed	174/108 Degre	water	TC	trock	Disca	r.	24a. Was an autopsy perform	ed? death	autopsy findings available to completion of cause of ?
VITA iicien: certific rector,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatient 2 🖸	ER/Outpatier	-	er: 4 ☐ Nursii	Death (Check only one ng Home 5 Resider 28d. Describe how	nce 6 Other (S	pecify)
To the Hospitel or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ation ot be 28e. Plac		Injury ome, farm, str (y)		k? Yes 2 □ No			Rural Route Number,
Hospitel of 24 hours a Funerel E	Medical Ce		Examiner: On the					place, and due to the car occurred at the time, da		
	Me	29b. Signature and title of certifier	tan	Mı	ט	29c. License	e number	29	d. Date signed (Mo	onth, Day, Year)
3		30. Name and address of person of the A (13) A - HC 31. Date filed (Month, Day, Year)	FRHMI 1	ND 8	21 N	Print) , EUTAN	STS	inte 308	Balt.	MD 21201
Sta Regist		NOV 0 5 20		Registrar's Signa	La .	Anask!				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** (5 Mela 10 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Deeth **Examiner** Hospita Age (In yrs. last birthday) **Funeral** Year) Days Months Min 70 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Prince George Directo 10g. Citizen of What Country? 10e. Street and Number or Items 23a Funeral Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 þ Specify: 3 ☐ Widowed 4 ☑ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) VIS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, s 1 and 2 should be fill f Health and Mental H item 27 Is markad ott To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother 20b. Place of Disposition (Name of cometery, crematory or other place, 20a. Method of Disposition permit. Pages 1 Department of t-Importent: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatule of Funeral Service License 22. Name and Address of Jacility Vaugha C Grelene Funeral Services Kandallotown, Mb, 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. SYNDROM Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical FAILURG Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events VASCULOPATHY Examine attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CONGESTIVE 3 Probably 4 Unknown 1 🗌 Yes 2 No PIRATORY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide within 24 hours a To the Funerel [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID A, GOORAY, MD, 1450 MERCANTILE LN, #217 LARGO MD, 20174 31. Date filed (Month, Day, Year) NOV 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 4 1 - For Stete Registrar 35120 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year MORRIS **Physician** ORENCE 6.40 PM NOV EMBER 2004 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HARBOR BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 3, 1929 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 13 F Yrs. Director 75 New Jersey 148 20 7349 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Nadical Examinar roust be multified at 1 ☐ Yes 2 X No Maryland Anne Arundel Baltimore Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 1 311 Panorama Way 21225 U.S. death by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic excent any injury or other traumatic excent any injury. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles J. Tembusch May Loretta Wilkenson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Lamartina / Daughter 311 Panorama Way Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem. 11/5/2004 Crownsville, Maryland * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ramerous !! lecome 23a. Eart1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician PNEUMONIA WEEK resulting in death) /Medical Due to (or as a consequence of) Examiner 3 YEARS DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Unknown HYPERTENSION BIPOLAR DISORDER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe CHRONIC OBSTRUCTIV PULMONARY DIS BASE 2 🗆 No 1 ☐ Yes 1 ☐ Yes 2 🗶 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funaraf I 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Chack only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Schahan OOO RES MD 11/04/04. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SADEKA SHAHANI, 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2004 Registrar Douxs

Amend item #1290, Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Privsician MILDRED 2004 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Town, or Local State of Birth (North, Day, APR. 19, **Examiner** BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2 🔀 F 81 216-16-3206 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahov Tre Medical Examiner must be nutified at 1 ☐ Yes 2 No Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3410 LYNN HAVEN DRIVE 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 [X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE Specify Completed by 3 ¥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ages 1 and 2 should be filed within nt of Health and Mental Hygiene.

If item 27 Ia marked other than or other traumatic event, ITEMS. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY DURAPAK COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be **SPEVAK** NATHAN DORA SEIRIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 JONES VALLEY CIRCLE - BALTIMORE, MD 21209 MICHAEL MILLER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) MOSES MONTEFIORE CEM. 11/02/2004 BALTIMORE, MD 21. Sign e Funeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aca TE Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be execu Due to (or as a consequence of) Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of deliver 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Tyes 2 3 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 2 1 No 1 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Division 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral I 29a, Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. October 30, 2004 29b. Signature and title of certifing 29c. License number 19502 Octo Benz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hespeta 6 ORCHNOC CONGNAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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NOV 0 5 2004

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar 35122 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 14 AM Month Day **Physician** -LORENCE 04,2004 MUSKIN NOVEMBER /Medical 4h. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner RANDALLS TO UN.

If Under 1 Year If Under 24 Hrs. B. Date of Birth
Months Days Hours Min.

JUN. 2, 1921 NORTH WEST HOSPITAL BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F 219-18-7919 83 Yrs. MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28e-f show traumatic avent, the Medical Examinar must be notified at 1 ¥Yes 2 □ No BALTIMORE Directo MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7111 PARK HEIGHTS AVENUE #801 21215 USA Nerns 23a death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Interportent: If item 27 is marked other than "naturel", or lier importent: If item 27 is marked other than "naturel", or lier any injury or other traumatic avent, the Medical Examt as any injury or other traumatic avent, the Medical Examt as any injury or other traumatic avent, the Medical Examt as 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BRAVERMAN **JACOBS** ISRAEL LILLIAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 FERNWOOD DRIVE - SEVERNA PARK, MD 21146 CHARLES MUSKIN / SON 20b. Place of Disposition (Neme of cemetery, crematory or other place, 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CEM 11/4/2004 REISTERSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Edwara (Kum 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) PULMONARY DISEASE burial-transit Exami OBSTRUCTIVE CHRONIC Due to (or as a consequence of): P.O. Box 68760. physician s the burial certificate be Physician/Medicai use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 TNo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy has 2 (No certificate 1 Yes 2 No To the Hospitel or Attending Physicien: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 100 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA ٩ this 28a. Date of Injury (Month, Day Yeer) funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Natural 1 Tyes 2 No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i 158 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 29c. License number mella MO D41410 November 04 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER EMEHTA Ci RAHD MUS TULIN HUSPITM RENTER スパろろ HURTHWEST 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar NOV 0 5 2004

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Departn State of Maryland / Departn Certific	nent of Health and cate of Death	d Mental Hy	giene 8004	35123
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Emily Lorraine	Morrow	2. Date of De Month	Day Year	3. Time of Death
	Examir		Franklin Square Hospital Center	City, Town, or Location of De Rose Ca Under 1 Year If Under 24 H	Irs. 8 Date of Bir		more
	Director			nths Days Hours M	lin. (Month, Da May 26	7, Year) Co , 1922 Ma:	nplace (State or Foreign untry) ryland
	within 72 hours after death with the Maryland ne	Director	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore	Edgemere			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the			of. Zip Code		10g. Citizen of What Co	
36	ter death w	Funeral	4 Barbara Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I	21219 Decedent of Hispanic Origin? , specify Cuban, Mexican, Pu	(Specify Yes or No	United S	
M RKOU	ours after ral', or Itel	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2% No	, specify Cuban, Mexican, Pu ′es 2□xNo <i>Specify:</i>	ièrtò Rican, etc.)	Specific	o, etc. ite
EMILY MOR	ithin 72 hours ne. han "natural",	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind life. DO N	Usual Occupation of work done during most of v OT use retired)	working	16b. Kind of Business/I	ndustry
7 2	filed w Hygien ther th		11 Years Clers 17 Father's Name (First, Middle, Last)		Name (First, Middle,	Retail Maiden Sumame)	
77/	nould be d Mental narked c	To Be	Victor A. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	Маз	rgaret E.	Stratemeye	
N N	and 2 sl ealth an m 27 la r her traur		Mr. William L. Morrow/Son 8055 s	dress (Street and Number or Stratman Road	Dundalk	, Maryland	21222
7	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other fraumatic event, Item.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetary, crematory Holly Hill	(Name of y or other place) Mem. Gdns. 10	Date D/30/2004	20c. Location - City or I Middle Ris	
д <u>+</u>	permit. Departn Importa any inju			ne and Address of Facility A-Ruck Funeral 2 Wise Ave. I			nc. 1222
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	2 evil a primy	naviy		
ý	Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
8760	rate be executed the burial-transit	al Exa	that initiated events resulting in death) Last				
G	the the	fedical	d				
Box	Attending Physicien: The law requires that the death certific redeath. refeath. stor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me		pic pregnancy or (specify)		23d. Date of deliving Month	very Day Year
Division of Vital Becords P.O.	ires that the de signed by the 1 be detached i	ğ	Part II. Other significant conditions contributing to death but not resulting in the underly	îng cause given in Part I.	23e. Did to	obacco use contribute to ∕es 2⊠No 3□ Pro	
Pecor	e law requir has been si je 2 should l	Completed			24a. Was	an 24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	icien: The l certificate ha ector, page	e Cor	25. Was case referred to medical	OC Pleas of F	1 ☐ Yes	rmed? death? 2⊠No 1 ☐ Yes	2 🗆 No
<u>></u>	physicien: this certific al director,	To B	examiner?	Chor	Home 5 Resid	ne) lence 6 □Other (Speci	(fy)
o no	nding Ph tth. :: After th		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury 28b. Time of (Month, Day Year) (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe h	low injury occurred	
Divis	spital or Attencours after death cores after death the color filled in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ictory, office	28f. Location (S City or Tow	Street and Number or Run n, State)	al Route Number,
	H T T J	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occu 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	rred at the time, date and pla ation, in my opinion, death oc	ce, and due to the courred at the time, of	cause(s) and manner as s date and place, and due t	stated. to the cause(s)
	To the Hos within 24 hr To the Fun completely	Me	29b. Signature and title of certifier	29c. License number	7	29d. Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	KD 21790	, 1	10/2010	J
	Sta	ite_	Dr Dawei Yang 9000 Franklin S 31. Date filed (Month, Day, Year) 32. Registrar's Signature	quare Drive	Baltu	more, ud	212-37
	Registr		NOV 0 5 2004 Server &	Sparks			

		State of Maryland / Department of Health and Certificate of Death	d Mental Hygi	iene 2004	35124
		1- State Registrate #23a PER PHY C837 11/05/04 JH 1. Decedent's Name (First, Middle, Last)	2. Date of Deatl	h	3. Time of Death
	Physicia	Harry Loctor Millor	October	Day Year r 31 2004	0400 ^M
	/Medica Examine	Ab City Town or location of D		4c. County of Dea	
		Harford Memorial Hospital Havre de Grad		Harfo	
	Funeral		Ain. (Month, Day,	Year) Co	thplace (State or Foreign puntry)
	Director	212-18-5390 1 L&M 2 F 83 Yrs. Usual Residence of Decedent	May 10,	1921 Ma	ryland
	land wo	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary -1 sh	Maryland Harford Bel Air			1 X Yes 2 No
	r 28a	Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show fraust be nettled at	298 L Canterbury Road 21014			SA
		298 L Canterbury Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, P 1 Never Married	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
36 18	or It	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Ma		Specify:	White
) e R 5-0036	filed within 72 hours after death with the Manylan Hygiene, ther then "natural", or Items 23s or 28s-1 show ont. It o Medical Examiner must be notified at			16b. Kind of Business	
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LL 2121	d with giene. rr ther	9 Insurance Underwrite		Insurance	Company
M	0 = 0 5	17. Father's Name (First, Middle, Last)	Name (First, Middle, M		2
- Indian		harry Elisworth Miller Lill:	ian Robert		
<u> </u>	2 sho and ls ma	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			
30	s 1 and 2 should f Health and Mer item 27 is marks other traumetic	Audrey Miller / Wife 298 L Canterbury Ro		LL, MD ZIU. 20c. Location - City or	
altimore.	permit. Pages 1 an Department of Heall Important: if item 2 any injury or other	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)			
3 =	rtmer rtant njury				l, Maryland
Ba	Depart Impo	21. Signature of Eureral, Service Licensee 22. Name and Address of Facility, McComas Funeral 50 West Broadway	Home, P.A.	Air Mary	land 21014
1		232 Port 1 Foter the disease or complications that caused the death. Do not enter the mode of dying, such as call	rdiac or respiratory arre		Approximate Interval Between
	Physician	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	АL		Onset and Death
	/Medical	resulting in death) Due to (pras a consequence et):			
	Examiner	Sequentially list conditions.			one week?
	sit od	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
(0	and I-tran	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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687	ificate g phys			107755	
Box	Attending Physicien: The law requires that the death certifica relative. The law requires that the death certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Yes 3 Yes 3 Yes 3 Yes 4 Y		23d. Date of de	
~	death	in the past 12 months? 1 Yes 2 No 9 Unknown		Month	Day Year
\bigcirc 0	that the de ed by the detached	9 Unknown	aza Didash	pacco use contribute to	e the sauce of death?
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Ť	Phys rat dii	CO. Details in Control Time of Control of		ow injury occurred	city)
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	s afte	27. Manner of Death 1			
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	© 29a. Certifier 1 Check only (Check only	place, and due to the ca occurred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	the H the E the F	one) and manner stated. 29b. Sinnature and the of certifier 29c. License number		9d. Date signed (Mon	
	To To	29b. Signature and the of certifier 29c. License number 100 47		10/21/	74
	الجرائيات	0001100		10/3/10	
	1011	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOI S. Clucar Away Have de Chara		2107	f.
1	Sta	Of Date filed (Month Day York) 20 Registrate Signature			
	Registr	rar INUVUO 2 CUU4			

Amend item#5, perfn, G838, 12, 17, 14, TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No U U L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician NOVEMBER Constance B. Michaelis 4,2004 4:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/3/1923 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 1 F Director 80 MD Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rthan "natural", or Items 23a or 28a-f shov the Modical Examiner must be notified at 1 XYes 2 □ No **Funeral Director** MD Highlandtown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 737 S. Montford Ave 21224 U.S.A. or Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sausage Packer Meat Factory permit. Pages 1 and 2 should be filled i Department of Health and Mental Hygis Important: If Item 27 Is marked other I any injury or other traumatic event. II! 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Antoinette Powlak Frank Phillips 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Holecek/Daughter 2 Old Forge Ct. Sparks MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/8/2004 Dundalk, MD 21. Signatore of Funeral Service License 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave Baltimore MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ACUTE MYOCARDIAL INFARCTION DAYS /Medical Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CONGESTIVE HEART FAILURE 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy rmed? 2ZNo 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1XInpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation s after dec. 1 TYes 2 No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a To the Funeral I 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 29c. License number m-ellamo 3 NEVEMBER OU D 41412 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA M. D. 76.21 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 14 35126 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3, Month Physician Alfred Norman November 11:15 A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 408 Shady Nook Avenue Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 94 Yrs. Germany Director 213-07-5546 1910 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ▼No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Shady Nook Avenue 21228 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cabinet Maker Self Employed 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johannes Nowotsch Eva Kochan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam M. Norman / Wife 408 Shady Nook Avenue Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or of once 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/04/04 ^ 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses ²². Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** potenision disease or condition resulting in death) to min /Medical Due to (or as a consequence of): Examiner rinory True Intertions Sequentially list conditions, any leading immedia-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine inding physician and use as the burial-transit The law requires that the death certificate be executed Prosto Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE: Division of Vital Records, P.O. Box 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ eq 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has 1 ☐ Yes 2 🗷 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ceaffier 29c. License number ,050830 mo 11/03/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 Fredorich Rd William Stado mo Ste 200 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 5 2004 Registrar

			For	epartment of Health and Mental Certificate of Death	Hygiene 2004 35127
			negistrar 1. Decedent's Name (First, Middle, Last)	2. Date of	f Death 3. Time of Death
	Physici		THELMA C. NEFF	Month	2 2004 12:57 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c County of Death
			Franklin Square Hospita	1 Rosedale	Baltimore
	Funeral		5. Social Security Number 214-14-0799 6. Sex 1	Months Days Hours Min(Month	f Birth 9. Birthplace (State or Foreign Country) MARYLAND
	Director		214-14-0799	3/1.	7/21
	yland how		10a. State 10b. County 10c. City, Town of	r Location	10d. Inside City Limits
	B-fs	ctor	MD N/A	BALTIMORE	1) Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code 21213	10g. Citizen of What Country? USA
	be filed within 72 hours elter death with the Maryland tal Hygiene. d other then "natural", or itame 23e or 28e-f show event, the Madical Exertains must be modified at	era	4124 COLEMAN AVE.		
	her de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Ves 2 25 No	 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	Black, White, etc.
93	rai', o	þ	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 🔯 No Specify:	Specify: WHITE
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an	id be lental ked c	To Be	LOUIS KONIECZNY	MARTHA BOI	RACKI
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours elter death with the Marylan Health and Mental Hygiene. Item 27 is marked other then "natural", or itame 23e or 28a-1 show titem treumatic event. The Madical Exertainer must be indiffied at		19a. Informant's Name/Relationship (Type, Print) 19b. N	failing Address (Street and Number or Rural Route N	umber, City or Town, State, Zip Code)
_	and 2 ealth ar n 27 is			¥	NGDON , MD. 21009
ore	Pages 1 nent of H int: If ite		1 ABurial 2 Cremation 3 Removal from State	crematory or other place)	BALTIMORE, MD.
Baltimore,	it. Pa rtmen rtent: njury		4 Donation 5 Other (Specify) ST. ST. ST. ST. ST.		
Ba	permit. Pages 1 and 2 Department of Health a importent: If Item 27 is any injury or other tre		Land Cartha	KACZORÓWSKI FUNERAL 1201 DUNDALK AVE. BA	HOME P.A. ALTIMORE, MD. 21222
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition ACUTE RES	Piratory Arre	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of		6
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d	ted nslt	nine	if any, leading to immediate if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	•	
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8760,	cate be executed physicien and the burial-transit	dlcai	d		
9	artifica ing ph e as th				
Вох	eath certif ettending for use as	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
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۵.	The law requires that the death certificate has been signed by the ettending to agge 2 should be detached for use as	by Physiclan/Me	Part II. Dther significant conditions contributing to death but not resulting in t	he underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
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E E		Corr		1 🗆 Y	performed? death? es 2 No 1 Yes 2 No
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	d s	. To	1 Yes 21 No 12 Inpatient 2 EH/Outp	atient 3 DOA 4 Nuising home 5	Residence 6 Other (Specify) ribe how injury occurred
on	Attending or death. ector: After by the fune	ation	1 Natural 5 Pending (Month, Day Year) Injury Accident investigation	M 1 ☐ Yes 2 ☐ No	
Division of	r Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		on (Street and Number or Rural Route Number, r Town, State)
	urs eft rel Di lled in				
	To the Hospitel or within 24 hours effe To the Funerel Dir completely filled in	edicai	29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, (Check only one) 1 ☐ Medical Examiner: On the basis of examination and/one) and manner stated.		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Me	29b. Signature and title of codifiery	29c. License number	29d. Date signed (Month, Day, Year)
)	í		1 my Ogujen 194	/ KES00000	11/2/04
	V		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) 1 Squarellive Ball	Finale MD 11) 27
	Str	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	1 JANVIEL INE BOLL	114016 111 × 120)
	Regist		NOV 0 5 2004	Sparks	

State of Maryland / Department of Health and Mental Hygien []

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month MIRRON 1 AWROS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 77 Q UTY mico If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**℃** M 2□ F Yrs Director 313 07 4990 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo BAU MALLAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Itams 23a 24 BALL death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1f Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married M Married ъ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced TIKW. "natural". 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if itam 27 Is marked other than "rapy injury or other traumatic avant, tra Med ance. Elementary/Secondary (0-12) College (1-4or 5+) 127 RS ANS PORTATION FOREMAN BETHLE HE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOOREW A. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 REIL -RENZ IARYLAND 20b. Place of Disposition (Name of 20c. Location - City Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Ais 3007 21. Signature of Funant Service Licensee 22. Name and Address of Facility 2 ROLANDERZMETTON BAUFUL ALTERNATURE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ovonani eucs Clu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 3 Probably 4 Unknown 1 ☐ Yes 20 No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Hospital or Attanding Pt 24 hours after death. 5 Funaral Diractor: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funaral D 29a. Certifier 🏗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of perse who completed cause of death (Item 23a) (Type, Print) 183 veeRd drup 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 5 2004

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Deborah Ann O'Beirne

4a. Facility Name (If not institution, give street and number)

St. Agnes Health Care

Physician

/Medical

Examiner

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Baltimore

2. Date of Death

November

Month

Day

05

n/a

4c. County of Death

Year

2004

0545

Year

7. Age (In yrs. last birthday,

State

·Registrar

31. Date filed (Month, Day, Year)

NOV 0 5 2004

)	t		State of Maryland / Department of Health and Mental Hygieng State of Maryland / Department of Health and Mental Hygieng State of Death Registrar State of Maryland / Department of Health and Mental Hygieng Reg. Meg. Meg. Meg. Meg. Meg. Meg. Meg. M	
Н	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Do OCTOBER	
	/Medic Examir		, and the state of	25, 2004 9:02P. M
			ST.AGNES HOSPITAL BALTIMORE	NIA
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 VF 7. Age (In yrs. last birthday) 1 Yrs. 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 1 Under 25 Hrs. 1 Under 25 Hrs. 1 Under 26 Hrs. 1 Under 26 Hrs. 1 Under 27 Hrs. 1 Under 27 Hrs. 1 Under 27 Hrs. 1 Under 27 Hrs. 1 Under 27 Hrs. 1 Under 28 Hrs. 2 Under 28 Hrs	9. Birthplace (State or Foreign Country)
	pur M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Maryla -f sho fied al	tor	MD N/A BALTIMORE	1 ⅓Yes 2 No
	th the or 28a or 28a	Funeral Director		itizen of What Country?
	is 23a	eral [11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	U.S.A.
ယ	after d	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 Mo	14. Race - American Indian, Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Mcdfeal Examiliar must be notified at	d by	3 ★Widowed 4 □ Divorced If Yes, Give Year or Dates:	Specify: BLACK
7.	n nat	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired)	Kind of Business/Industry
212	filed with Hygiene other tha	Com	12th grade N/A Homenlaker	DOMESTIC
and	ntal H	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider SAMMIE HUTCHIN LUVENIA NEA	,
Maryland	2 should be and Mental is marked o	To	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rural Route Number, City</i>	
Ž	and 2 ealth a m 27 is		DEBRA REDMOND/DAUGHTER 605 LUCIA AVENUE BALTIME 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. L	DRE, MD 21229
Jore	ages 1 nt of H :: If ital			
Baltimore,	parmit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Dapartment of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, If a Modical Examinar must be notified at ODGe.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signalure of Funcial Service Licenses 22. Name and Address of Eacility	randore, MD
<u>~</u>	parmi Dapa Impo any ir		21. Signature of Funcial Service Licentes 22. Name and Address of Facility VAUCHN CREENE FUNCIAL SIGN BALTIMURE NATIONAL PIKE	, SERVICES BALTOMO 21229
			23a. Part1. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic cardiovascular displayed to (or as a consequence of):	
П	Examiner		Sequentially list conditions, b.	
	nsit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	
o O	ate be executed hysician and the burial-transit		that initiated events c. resulting in death) Last Due to (or as a consequence of):	
8760,		dlcal	d	
Box 6	death certifica e attending ph ed for use as th	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
œ œ	e death he atte	sicla	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)	Month Day Year
P.O.	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	/ Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco	use contribute to the cause of death?
rds	w requires been sign should be	ed by	Red observed 1:	No 3 Probably 4 □Unknown
Records,	faw renas bee	Completed	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a H	n: The ficate h nr. page		performed? 1X Yes 2 No 25. Was case referred to medical 26. Place of Death. Charle only and	death? 1 Yes 2 No
f Vital	Physician: The lav this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 1 Inpatient	6 □Other (Specify)
n of	ing Ph	:uo	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury Work?	
Division	Attanding r death. actor: After	ficat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Accident Accident Services) Accident 1 Yes 2 No 28f. Location (Street and Accident Services) Accident 1 Yes 2 No	nd Number or Rural Route Number,
á	tal or after safter al Dira	Certification:	4 Homicide building, etc. (Specify))
	To tha Hospital or Attanding I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer.	Medical	29a. Certifier (Check only one) 27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.	and manner as stated. I place, and due to the cause(s)
	To tha within 2 Fo tha comple	Med		te signed (Month, Day, Year)
	in.		O.C.M.E. OCTO	DBER 30,2004
1	Jex Miller		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TACK M. TIMS M.D. 111 Penn Street, Baltimore,	Maryland 21201
	Sta		01 Date Fled (Month Day York)	1-ALY 10114 212U1
	Registr	aŗ	NOV 0 5 2004 Service Signature	

JOYCE PRIDGETT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Las Registrar Certificate of Death Red. No. 35131 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 20, 2004 **Physician** 0466 HNN 12:22p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1006 DURHAM STREET BALTIMORE CITY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months 228-60-8763 MAY 31, 1945 **Director** Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show other traumatic avent. It a Madical Examiner must be notified at BAITIMORE 1 Yes 2 No MD Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 6 Itams 23e 1006 St 21205 N 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: Specify: BIACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic 9 MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental h UNK WILLIE MATHEWS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2321 E. LAFAYETTE AVE. BAILO, MD. 21213 itam 27 LINDA MORRIS I-MENI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State jo i 1°5 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. MT. CARMEL 10-28-04 BAlto MO ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hickory Zighe Fren Suc. P.A.
P.O. Box 67338 BALTO. MD. 21215 21. Signature of Funeral Service Licenses Michael 23a. Part1. Enter the disease, or disease, or disease, or disease, or disease, or disease, or disease, or disease, or disease on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No ρ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, sign 1 be 1 ☐ Yes 2 No 3 Probably 4 □Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2. No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 2 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural investigation 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour.
the Funaral Director of the filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and OCME OCTOBER 21, 2004 30. Name and address of person who completed of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) NOV 0 5 2004 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 2004 35132 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaar **Physician** Louis D. Patti, Jr. 12:45 PM November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston Maryland 1612 Angleside Rd. 8. Date of Birth (Month, Day, Year) Nov. 27, 1916 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2 ☐ F Yrs. Director 218-14-2830 87 Nov. Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Baltimore Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23g or 21047 1612 Angleside Road u. s. Α. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ⊠Yes 2 No If Yes, Give Year or Dates 1942 - 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Ş Q 3 Widowed 4 Divorced White 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Menial Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, It a Madia 2006. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis D. Patti, Sr. Mary Bruno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Angleside Rd., Fallston, Maryland 21047 Antoinette V. Patti (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □ Donation 5 NOther (Specify Mausoleum Most Holy Redeemer Maus.) 11/5/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes e ef Euneral Service License 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician HTN Completed by Physician/Medical IF FEMALE: NA 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 6 L 4 (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attanding Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Cther: 4 Nursing Home Residence 6 Other (Specify) 1 Yes R No this s after death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -48025 (MD) MUSTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESACO AVE, BAUTO, NO 21237 M- QARNI, MD 1224 SOIHALL NOV 0 5 2004 32/ Registrar's Signature 31. Date filed State Registrar

State of Maryland / Department of Health and Mental Hygienes 35133 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month DE **Physician** 1.55 A CATHERINE **EMMA** PERRONE 4 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ILEN BURKIE SHINE ARUNDA 13 RA ARUNIDEL HOCPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 K F 216 74 9583 84 1920 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner coust be notified at 1 ☐ Yes 2 XNo MD Anne Arundel Directo Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 8460 Rugby Rd. 21122 U.S.A. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: White 3 Widowed 4 □ Divorced *natural* Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker Pages 1 and 2 should be filed nent of Health and Mental Hygiant: If Itsm 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mathia Franz Katharina Freichman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Perrone - Son 8316 Wicomico Rd. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Entombment permit. Pages 1 Department of H Important: If Its any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 KOther (Specify) Cedar Hill Cem 11/8/2004 Baltimore, MD 22. Name and Address of Facility G. J. Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Dr. Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** DISBARE DNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed RAPHSION and Due to (or burial-t as a consequence of): physicien Physician/Medical as attending f 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Division of Vital Records, P. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 🗆 No 3 Probably 4 Yunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed? certificate 1 ☐ Yes 2 ₩ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deal 9 Funeral Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29b. Signatur nd title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 · MUD NOVEMBER 4 2004 D95179 Oc 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) listings 13 Elen Bournie MID 21061. 31. Date filed (Month, D 32. Registrar's Signature State Registrar

Box 68760

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Pakula Adolph 3 2004 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bultinge KUAS John HOSPITAL A If Under 1 Year | If Under 24 Hrs Months Days Hours Min Date of Birth (Month, Day, 5. Social Security Number Funeral 6. Sex In yrs. last birthday Birthplace (State or Foreign Country) Year, 213-12-1 2 F Director OV Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director BALTIMORE 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with .S. A Items 23a 81 -Leel 57 21231 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No U 5
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Dep. rtment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iter any njury or other traumatic event, the Neulcal Evant Black, White, etc. 1 Never Married 2 Married U.5 Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced WhiTe NAUY Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 72 Tevelore ILA CORP NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAKULA BOLESLAW AtheRine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7651 YAK PASADENG 21122 ERRY 500 13 M 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State u 4 □ Donation 5 □ Other (Specify) STANISLAUS COM 5/04 21. Signature of Funeral Service Licenses

22. Name and Address of Facility

HARTIEN MILLER - STELLA FO

75 27 hayford RD. Button M

(3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. FUNERAL Home Bolto. Ms Approximate Interval Between Onset and Death ediate Cause (Final Physician Stroke di ease or condition resulting in death) 6 days /Medical Due to (or as a consequence of): Examiner Hypertension Year = Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Colon Alzheimer's Disease 1 ☐ Yes 2 ☑No 3 Probably funeral director, page 2 should 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform rmed? 2 ☑ No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 November 3, 2004 Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tennifer Berkeley, 600 North Wolfe Street, Baltimore, Maryland 21287 15 31. Date filed (Month, Day, Year) 32. Registrar's Signature State V 0 5 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrer	State of Maryland / Depa	artment of Health and M rtificate of Death	ental Hygie	2004	35135
			Decedent's Name (First, Middle, Last			2. Date of Death Month		3. Time of Death
	Physicia /Medic		PAUL	PLUMMER		10 3	Day Year 1 2004	5:20 A M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Francis		MARINER HEALTH OI 5. Social Security Number 6. Se		FOREST HILL If Under 1 Year If Under 24 Hrs.	8. Date of Birth	HARFORD 9. Birtho	place (State or Foreign
	Funeral Director			M 2□F 73 Yrs.	Months Days Hours Min.	Month, Day, Ye	Par) Coulo	place (State or Foreign http) LYLAND,
	nyland thow		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Be-f s	Funeral Director	MD Hart	ord Wh	itetord.	1.0		1 □ Yes 2 No
	with t	١	10e, Street and Number	and Rd	10f. Zip Code	Tog.	Citizen of What Cou	ntry !
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	city Yes or No-	14. Race - Americ Black, White,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other then "naturel; or items 23a or 28e-f show other treumatic event, Ite Madical Examination and in the Light at I will be a colling at	by Fu	1 Never Married 2 Married	1 P Yes 2 □ No V Yes, Give	1 ☐ Yes 2 No Specify:	ritoari, etc.)	Specify: 1/	hila
ö	hours turel	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:	dent's Usual Occupation	161	o. Kind of Business/In	dustry
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Maryland	be fill htal Hy ad oth	Be	17. Father's Name (First, Middle, Last)	Plusana	18. Mother's Name	(First, Middle, Mai	den Sumame)	
Ž	should be ind Mental s marked umatic ev	္	19a. Informant's Name/Relationship (T	. Tlummec	ng Address (Street and Number or Rura	I Route Number, C	ity or Town, State, Zid	Code)
Ma	1 and 2 s Health ar em 27 ls other treu		Elizabeth J. F	lung mac m. G. 757	to Whiteford PH.	Whitef	ord mo	21160
ore,	0 0		20a. Method of Disposition 1 Burial 2 Decremation 3	20b. Place of Dispo	esition (Name of	ate 200	. Location - City or To	own, State
Ĕ	Pages ment of tent: If it		4 □ Donation 5 □ Other (Specify,	FUALISTING	EPHICHADFI-BUILD	F	ocest Hil	1, mb
Baltimore	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	22	2. Name and Address of Facility 3	EWPORT	DR. FOR	EST HILL,
	402.00		23a Part 1. Enter the disease, or comp	lications that caused the death. Do not ent		LAPEL-BE	ELAIR, M	Approximate
k	re-		shock, or heart failure. List only of immediate Cause (Final	ne cause on each line.				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Que lo (or as a orn requince o):	- Accident			en Hours
	Examiner	L	Sequentially list conditions,	b				
7	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	be executed sician and burial-transit	Examine		c			_	
8760	ate be hysicia the buri			d			4	
9	death certificate e attending phys d for use as the	Physician/Medical	IF FEMALE:					
Вох	eath certifica attending pl	lan/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
o.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	J Other (specify)			
<u>α</u>	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
ords	w requires that s been signed t s should be deta		trevious (erepro Vascula	r Accident	1 ☐ Yes	2 No 3 □ Prob	ably 4 Unknown
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al H	Th ate pag					performed		No No
Zi.	Physicien: Th this certificate ral director, pag	э Ве	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	26. Place of Death Other: 4 The useing Hos		e 6 □Other (Specif	
of	ding Phys	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time o		28d. Describe how i		y)
ion	Attending Ph death. ctor: After th y the funeral	atio	Matural 5 Pending investigation	(Worth, Day Fear)	M 1 Yes 2 No			
Division	d or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	Il Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a, Certifier 1 Certifying Phy	sician: To the best of my knowledge, death	h occurred at the time, date and place a	and due to the cause	e(s) and manner as o	tated.
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier	12000	29c. License number	29d.	Date signed (Month,	Day, Year)
}			1 (INam	y MC m	D19583	1	lovenb	er 1,200
	111		30. Name and address of person who of DR. MANUEL LAZAT	ompleted cause of death (Item 23a) (Type, IN 8 LAW STREET,		1		,
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	ADDROBER, FID 2100			
	Registr		NOV 0 5 2004	General G	South			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** PETERS PAULINE 10:45 AM 2004 NOVEMBER /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WHITEWAY 3200 BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months 1 M 2 F Yrs. 213-82-1000 95 Director June 29,1909 Pennsylvania Usuel Residence of Decedent the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or flams 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Marvland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death with it Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "nature." any injury or other traumatic events. 3200 Whiteway Road Funerai 21219 United States
14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: Completed by White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Oduch Frank Bartol 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Thomas G. Peters/Son 3200 Whiteway Road Edgemere, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DXBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 11/6/2004 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of F neral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Regorn 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the usase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart if ure. List entry one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician end i for use es the bunel-transit or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Due to (or as a consequence of): certificete has been signed by the a linector, pege 2 should be deteched? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uae contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Anemia ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy Bilatual Cataracts 2 XNO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 □Other (Specify) 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No ours efter death.

erai Director: A
filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funeral C completely filled Hospital 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) NOVEMBER 3, 2004 romas 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) 5505 HOPKINS BAYVIEW CIRCLE, BALTIMORE, MD 21224 THOMAS TINUCANE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2004 20 medianes Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3 LUCILLE PERKINS 004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sand Tawn Nursing Mone N/A BALTIMORE 5. Social Security Number 6. Sex Age (In yrs. last birthday) tf Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, Year) 8-17-1914 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🗓 F MARYLAND 90 Director 218-09-7485 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or Items 23a or 28a-1 shov traumatic event, the Medical Examinar must be nutified at 1X Yes 2 □ No MD. N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21217 USA 2804 AUCHENTROLY TERR. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No BLACK Specify: Specify: þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) -12--0-SEAMSTRESS SEWING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL MACKEL NANNIE BEAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat once. WALTER G. HILL(SON) 2804 AUCHENTROLY TERR. BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MT. ZION CEMETERY 11-4-2004 BALTIMORE, MARYLAND 21. Signat neral Service Acensee VERNON BAILEY 22. Name and Address of Facility BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 wher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate dause (Finat ODS huctive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed physician and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the use as attending IF FEMALE 23c. tf yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the o 9 Unknown 9 Unknown á Records, P. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 No 2 HO 1 TYes 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 \ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eutan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygien

			For State of Maryland / Department of Health State Of Maryland / Department of Health For State Of Maryland / Department of Health Certificate of Dea	in and Me a <i>th</i>	ental Hygien Reg. N	2004	35138
ı	° Physicia	an	1. Decedent's Name (First, Middle, Last) Betty L. Rea Ves	2	2. Date of Death Month Da		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locati	tion of Death	November 40	3 2∞4 County of Death	
			Sinai Hospital Bultin			7	IA
	Funeral Director		5. Social Security Number 6. Sex 1 M 20XF 7. Age (In yrs. last birthday) 1 If Under 1 Year If United Security Number 1 Yrs. Usual Residence of Decedent		Date of Birth (Month, Day, Year) (D · O7 · 1	128 9. Birth Con	place (State or Foreign intry)
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_	ter dez	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 KNo	c Origin? (Speci xican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
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7	filed with Hygiene. other than	Completed	Elementary/Secondary (0-12) College (1,40r 5+) 12+h grade NA ADMINISTRATIVE			F.B.	1.
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aryı	2 should and Mer is marke eumatic	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 19b)				p Code)
	f Health f Health item 27 i		CHARLENE REAVES/DAUGHTER 2505 ALLENDAL 20a. Method of Disposition (Name of	LE RD		ocation - City or T	
Baltimore,	1000	1000	1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) ARBUTIS	11.00	7.04 B		
ga	permit. Pag Department Importent: I eny injury o			RE NAT	FUNERAL LPIKE B	SERVICALTO, MI	5 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final	h as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Hyper kalemia Due to (or as a consequence of):				
	Examiner	L.	V. J. S. G. I. a.				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
68760,	rificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):				
89	nificate ng phy as the	Medicai	IF FEMALE:				
O. Box	The law requires that the death certi lie has been signed by the atlending page 2 should be detached for use a	Physician/N	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of deliving Month	very Day Year
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ords	w require been sig should b		Hypertension Cordiomyopathy		1 ☐ Yes 2	□No 3□Pro	bably 4 Unknown
Il Records,		Completed	Cardiomyopathy		24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vita	Physicien: Th r this certificate inal director, pag	o Be	examiner/		Check only one)	C []Other (C	4.1
o c	ding Phy h. After this funeral d	\vdash	27. Manner of Death 12 Natural 5 Pending (Month, Day Year) 13 Natural 5 Pending (Month, Day Year) 14 Natural 5 Pending (Month, Day Year)		d. Describe how inju		19)
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2	s after s after et Dire ed in by	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Stat	e)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director After this certifical completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	te and place, and death occurred	d due to the cause(s at the time, date an) and manner as d place, and due	stated. to the cause(s)
)	To the l within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License numb			te signed (Manth	
1	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		No		2004
	り		Chad J. Hansen, M.D. 2401 W. Belvedere Ave	e Bal	timere 1	0 212	15
:	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 2004 32. Regignar's Signature Apouth	/			

			1 - For State Registrar	of Maryland / Dep <i>Ce</i>	artment of Health and Mertificate of Death	lental Hygie		35139
	o Physici	an	1. Decedent's Name (First, Middle, Last) Lewis Robin	2.50A		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death	11	4c. County of Death	1.12 /1
				1 Canter	Baltimere If Under 1 Year If Under 24 Hrs.	O. Data of Blats	0.514	
	Funeral Director		219-01-3213 1XM 201	7. Age (In yrs. last birthday) 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye (U)08/19)	ar) Cour	olace (State or Foreign ontry) TO CARCINA
	nand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		1	10d. Inside City Limits
	e Many tarf sh	ctor	MARYAMI	BAL	TIMORE			Yes 2□No
	with th	Director	10e. Street and Number	APT:	10f. Zip Code		Citizen of What Cour	ntry?
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36	72 hours after death with the Maryland naturel', or items 23e or 28e-f show lical Examiner must be notified at	by Fur	1 Never Married 2 Married 1 Yes,	s 2 No 7742 Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, Specify: 6/	
5-0036	72 hours naturel',		15. Decedent's Education	16a. Dece	edent's Usual Occupation	166	o. Kind of Business/In	
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Maryland	nould be d Mental narked c	To B	HENRY Robinson		MINNIE	DAVIS		
Many	ges 1 and 2 should t of Health and Mer If item 27 is marke or other treumatic		19a. Informant's lame/Relationship (Type, Print)	ersonal 196. Mail	ing Address (Street and Number or Rura	al Route Number, Ci	-	
	Healther 1		Victoria Hamilton-R 20a. Method of Disposition	20b. Place of Disp	osition (Name of matory or other place)	Altimure 200	Location - City or To	own, State
OM!	Pa e H		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		ematory or other place)	2004 B	ALTIMUR	e ned.
Baltimore,	permit. Pag Depertment Importent: any njury once.		21. Signalure of Funeral Service bicensee	2	2. Name and Address of Facility ${ m The}$	Derrick (C. Jones F	/H, P.A.
			23a. Part1. Enter the disease, or complications the	at caused the death. Do not en	511 Park Hgts. Ave.			Approximate
	Medical Examiner		shock, or heart failure. List only one cause of	n-dach line.				Interval Between Onset and Death
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		er	Sequentially list conditions, if any, leading to immediate Due	to (r as a consequence of):				fouch
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Вох	leath certific attending p	Physician/Med	23b. Was decedent pregnant 1 Liv		⊒Ectopic pregnancy		23d. Date of delive Month	ery Day Year
O.	at the de by the a tached f	nysic	1 Type 2 No 4 Pri	egnant at time of death 5[known	Other (specify)			
s, P	es that igned b	by PI	Part II. Other significant conditions contributing to	11 . 1	N. 1 1		co use contribute to th	
ord	w require been si should I	eted	End Stage Renal Disease	har about	Diabetes	1 Tes	2 No 3 Prob	
of Vital Records,	The law ate has page 2 s	Completed	disease	hranic obstruc	TIVE pulmonary	24a. Was an autopsy performed	prior to con death?	psy findings available mpletion of cause of
ital	<i>ca □□</i>	Be C	25. Was case referred to medical		26. Place of Death	1 ☐ Yes 2 ☒ 1 (Check only one)	No 1 ☐ Yes	2No
of V	his I dii	၉	1 ☐ Yes 2 No Hospital: 1	npatient 2 ER/Outpatie	The state of the s	me 5 Residence	6 Other (Specify	y)
Division o	Attending P r death. sctor: After t by the funera	ation	1 Natural 5 Pending (N 2 Accident investigation	onth, Day Year) Injury	Work? M 1 □ Yes 2 □ No	Edd. Describe flow ii	njury occurred	
	l or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined 28e. Pl. 4 Homicide	ace of Injury - At home, farm, st ilding, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	ll Route Number,
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical Ce	29a. Certifier 1 Le Certifying Physician: To	the best of my knowledge, deal	th occurred at the time, date and place, and experience of the court o	and due to the cause	e(s) and manner as st	tated.
	o the hithin 24 o the Formplets	Medi	one) and m 29b. Signature and title of certifier	anner stated.	29c. License number		Date signed (Month,	
	⊢≯Fŏ		1 Subble	MO	19557	2.4	101/201	24
	\		30. Name and address of person who completed of Bradley Robothom	ause of death (Item 23a) (Type,	Print) St. Baltim	OR MD	21201	
	Sta Registi			Registrar's Signature	Print) St. Baltim	1	<u>-</u>	
-		144	/	,	•			

			State of Maryland / Department of Health and 1- State Registrer Certificate of Death			35140				
	Physici	an	1. Decadent's Name (First, Middle, Last)	2. Date of Death Month	Qay Year	3. Time of Death				
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath /	4c. County of Dea					
	Funeral		5. Social Security Number 6. Sept 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Irs. 8. Date of Birth	9. Bi	A hthplace (State or Foreign				
	Director		216-68-7343 1 M 20 F 47 Yrs. Months Days Hours M	in. Oct. 11,10	757 M	aryland				
	anyland show	J.	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No				
	or 28e-f	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What C					
	ns 23a	Funeral D	15 5 4 NICKean Ave. 2/21/ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Am					
36	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "netural", or itams 23a or 28e-f show event, the Medical Examinar must be notified at	by Fur	Armed Forces? If Yes, specify Cuban, Mexican, Pu 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	erto Rican, etc.)	Black, Whi	ite, etc.				
15-00	"netura			working 16b	Kind of Business	Andustry				
212	filed within 72 Hygiene. hthar than "nei ant, the Medic	Completed	Elementary/Secondary (0-12) College (1-4or 5+) III. DO NOT use retired) OUSe Reepin	q (leanir	g Service				
land	ould be file Mental Hy arked oth atic evan	To Be	17. Father's Name (First, Middle, Last) 18. Mother's N	lathe (First, Middle, Maid	en Sumame)					
Maryland 21215-0036	and and ls m	_	-	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Number, Cit	y or Town, State,	Zip Code)		
	ges 1 and at of Health If itam 27 or other tr	l li	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place)	/	Location - City or	Town, State				
Baltimore,	t. Pa tmen tant: njury		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address on Facility	1/2004 L		wne, Ma.				
Ä	permi Depar Impor any ir		23a, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card		Home 21	Z/6 Approximate				
	Physician	Š	shdckf or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	indo or roopinatory arroot,		Interval Between Onset and Death				
	/Medical Examiner	niner	resulting in death) Due to (or as a consequence of):			unk				
	ted nsit		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury but lighted septice.						
90,	icate be executed physician and s the burial-transit		that initiated events cresulting in death) Last C. Due to (or as a consequence of):							
68760,	tificate by physic as the b	ledica	d		120-00					
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year				
P.O.	that the de ted by the a detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?				
ords,	w requires to been signed should be a	ed by	ed by	ted by	ted by	ed by	1/11/ ECDE			robably 4 Unknown
Records,	: The law recate has be page 2 sho	Completed		24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of				
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical 26. Place of D	1 ☐ Yes 2 M Death (Check only one)	No 1 ☐ Yes	5 2 No				
of	Phys ral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 Residence		ocify)				
Division	Attandin death. ctor: Af y the fur	Certification	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street	and Number or R	ural Route Number,				
D	urs after arel Direc		4 Homicide building, etc. (Specify)	City or Town, St						
	To tha Hospitel or Attanding within 24 hours after death. To the Funarel Director: After completely filled in by the fune	edical		courred at the time, date a	and place, and due	e to the cause(s)				
	To tha Pwithin 2 To the I	Σ	29b. Signature and title of certifier 29c. License number	29d. I	Date signed (Mont	th, Day, Year)				
Y	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony R. Natdi 200 E. West s	1. 2 Balti	uve, N	12 21230				
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 5 2004 Aparts Aparts Aparts							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene O. O.

			1 - For State Registrar	State of M	aryland	Cei	artinent of F rtificate of	teaith and i <i>Death</i>	vientai Hygi Ri	en 2 0 0 L	+ 35141
	Physici	an	Decedent's Name (First, Middle, Last) Date of Death Month Date						Day Ye	3. Time of Death	
	⁶ /Medic	al	Marlene June Riley 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			r 3 200	
20	Examin	ięr	529 South Fult				Balti			N/A	· outil
	, Funeral Director		5. Social Security Number 6. 217 34 5227	6. Sex 7. Age (In yrs. last birthday) If Ur Mont					8. Date of Birth (Month, Day, June 1,	Year) 9.	Birthplace (State or Foreign Country) Maryland
	ō		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Four or La					
36	Maryla f ahor	JO.	Maryland N/A			ltimo					10d. Inside City Limits 1½ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number	-	Du.	LOTINO	10f. Zip Code		10	g. Citizen of Wha	t Country?
	23s o	ral D	529 S. Fulton	Avenue			212	23		U.S.	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avant, it e Medical Examiner must be notified alonge.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 200 No		pecify Yes or No- o Rican, etc.)	Black, V	American Indian, Vhite, etc. Vhite
00-6	72 hou natura irat E	ted	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occup	ation	ting 1	6b. Kind of Busine	
21215-0036	vithin 7 ne. han "r	Completed by	Elementary/Secondary (0-12)	College (1-4or	i+)		kind of work done DO NOT use retired		King	Warehous	20
2	filed v Hygie othar t		9th 17. Father's Name (First, Middle, La.	st)		ASS	embly Wo		ne (First, Middle, N		
lan	uld be Mental rkad o	To Be		L. Beall					y K. Pete	- '	
Maryland	2 shou and N is ma is ma	-	19a. Informant's Name/Relationship						ral Route Number,		
	1 and dealth am 27 thar tr		Michelle Vana /	Granddaug			Tieman C sition (Name of	circle		nie, Mar	yland 21061
nor	Pages nent of h int: If its iry or o		1 ☐ Burial 2 【2 Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		cem	etery, crer	natory or other place Crematory		. 1		
Baltimore,	permit. F Departme importan any injur		21. Sign whe of Funeral Service Lic		Day.	1 22		ss of Facility GC	nce Fune	ral Serv	, Maryland ice, P.A. aryland 21225
	¥1		23a. Part1. Enter the disease, or es	melications that caused	the death.						Approximate Interval Between
)	Physician /Medical		Onset and Dea								Onset and Death 4 mentus
	Examiner	100	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ice or).							
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687	tificate ng phy as the	Aedical	is some	0.					,		
.O. Box	ath cer ttendir or use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
٥.	w requires that the de been signed by the a should be detached fo	by	Part II. Dther significant conditions	contributing to death b	ut not resultin	ng in the u	nderlying cause giv	en in Part I.	23e. Did toba		e to the cause of death? Probably 4 Unknown
Il Records,	Physician: The law rethis certificate has beral director, page 2 sho	Completed							24a. Was an autopsy perform	prior	
Vita	Physician: this certifica ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:			t 3 DOA Oth	00	th (Check only one		
ot		-	1 Yes 2 No	28a. Date of Inju	ry 28	3b. Time of	1 JU DOA	4 Nursing ra	ome 5 Resider 28d. Describe how		(pecify)
ion	anding ath. or: Afte	atlo	1 Natural 5 Pending 2 Accident investigat		(Year)	Injury		k? Yes 2 □ No			
Division of Vital	al or Attending safter death. I Diractor: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home c. <i>(Specify)</i>	ə, farm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral completely filled in	Medical C	29a. Certifier 1 Certifying I (Check only one) 2 Madicel Ex-	Physician: To the best aminer: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the car rred at the time, dat	use(s) and manner e and place, and	as stated. due to the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier	1) 1/	16 .441)	29c. Licens		29	d. Date signed (Me	onth. Day, Year)
,	Ω		· VIIII	Young Kw	AC! WI	/		061434		11/04/20	<i>U</i> 4
1	0		30. Name and address of person wh	o completed cause of d 2 South Gr	eath (Item 23	3a) (Type,	Balti	more, n	11) 2120)	
4	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 2004	32. Registr	ar's Signatur	9	parts				

Patient From as

Funeral

Director

Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-1 ehow othar traumatic evant, II to Modical Examination unit be notified at Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 6810 WESTBROOK ROAD 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MANUFACTURER 17. Father's Name (First, Middle, Last) Be 12 should be fi and Mental H ROSENBLATT **JOSEPH** MARIE 2 19a. Informant's Name/Relationship (Type, Print) Department of Health a important; if item 27 is any injury or other tra 6810 WESTBROOK ROAD GLORIA HACK / FIANCEE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 NBurial 2 XCremation 3 Removal from State HILLTOP SERVICE CORP, 11/4/2004 * 4 Donatier 5 ☐ Other (Specify) f a.f. Enter the disease, or shock, or heart failure. List striat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, seaon each line. ACUTE RENAL Immediate Cause (Final FAILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ONTRAST INDUCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AdenoCavilnoma ot ancienticobiliary Origin Completed Fibrillation 24a. Was an autopsy perform page 2 s Au per li pridemi a
25. Wa case referre to medical
examiner? 1 Yes To the Hospital or Attending Physician: director Be 26. Place of Death (Check only one) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: Certification: To 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Natural 2 Accident Injury 5 Pending after death. Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29c. License number 29b. Signature and title of certifier MD 30. Name and address of person who complet ed cause of death (Item 23a) (Type, Print)

	1	State of Maryland / Dep	eartment of Health and Me ertificate of Death	ental Hygiei Reg.	2004 35143		
Physician /Medical	t	Decedent's Name (First, Middle, Last) SEMYON	RAPOPORT	2. Date of Death Month November	Day Year 2 2004 10: 27 P M		
Examiner	1	4a. Facility Name (If not institution, give street and number) Sinc: Hospital of Bultimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	4c. County of Death N/A 9. Birthplace (State or Foreign County)		
Director		213-27-7747	ocation	0(CT. 16, 1	10d. Inside City Limits		
ifier death with the Mar flems 23a or 28e-1 si ther must be notified Funeral Director		MD N/A 10e. Street and Number 2.615 FORDS LANE #21.4	BALTIMORE 10f. Zip Code 21215	10g.	1 1 1 1 1 New 2 □ No Citizen of What Country?		
1215-0036 within 72 hours after death with the Maryland one. than "natural; or Items 23a or 28e-1 show the Medical Examinar must be notified at mominated by Funeral Director		3615 FORDS LANE #314 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE		
21215-0036 ed within 72 hours all yglene gerthan "natural", or t, the Mudical Exam Completed by E	nubleren	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) KEEPER	g	. Kind of Business/Industry		
Maryland : d 2 should be filed th and Mental Hyg th and Mental Hyg th sarked othe treumatic event.	0	17. Father's Name (First, Middle, Last) AVRAM RAPO	PORT RAHIL	(First, Middle, Maid	den Sumame) (UNKNOWN)		
C = 14 F		KHAYA KLARA RAPOPORT / WIFE 3615 20a. Method of Disposition 1 \(\Delta \) Burial 2 \(\text{Cremation} \) Cremation 3 \(\text{Removal from State} \)	ematory or other place)	BALTIMOR ite 200	E, MD 21215 Location - City or Town, State		
Baltimore, permit. Pages 1a Department of Hee Importent: if Nem any Injury or othe once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOL	LEVINSON DAD - PIK			
cate be executed white the burial-transit the burial-transit character by the burial-transit c	LYD	23a. Parti. Enter the disease, or complication hat caused the death. Do not e shock, or heart failure. List only one duse on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	inal Bleeding	ioopiatory unioo,	Approximate Interval Between Onset and Death		
death certifi e attending d for use as	by Physician/Me	Completed by Physician/Me	ieted by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
requirements				Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacc	
Re la la la la la la la la la la la la la		Kidney Stones		autopsy performed 1 ☐ Yes 2 ☑			
n of ng Phy fter this neral d	2	25. Was case referred to medical examiner? 1 Yes 2 No			6 □Other (Specify) njury occurred		
Itel or res after rel Dir. led in 1		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, St	,		
the Hospi nin 24 hou the Funer npletely fill		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred	d at the time, date a	and place, and due to the cause(s)		
To the withing the transfer of the the transfer of the transfe	2	29b. Signature and title of certifier MO	29c. License number D59062		Date signed (Month, Day, Year)		
2		30. Name and address of person who completed cause of death (Item 23a) (Type Chad Hansen MD 2401 W B	e. Print) Relvedere Ave, Balt				
State Registrar		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Solvedere Ave, Balt				

		-	1 = For State Registrar	State of Maryla	and / De	epartment of F Certificate of	lealth and N Death	ental Hygie	ene 200	4 35144
	**	~	1. Decedent's Name (First, Middle, Last)		0			2. Date of Death	Day Yea	3. Time of Death
44	Physicia /Medic		Helena	/	Sao			November	1,200	£ 5:01 AM
	Examin	_	La. Fecility Name (If not institution, give		C. 1	.0 1 .	or Location of Death		4c. County of De	eath
					Center		If Under 24 Hrs.	P. Date of Righ	0.5	Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sec. 218-74-6971	M 2□F 95	rs. last birtho Yr:	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 12-23-1	908 P	Country)
		-	Usual Residence of Decedent							
	rylan		10a. State 10b. County		City, Town o					10d. Inside City Limits
	Ba-1-8	Director	Md. Baltimo	re	Dunda					1 ☐ Yes 2 ☐ No
	with the		10e. Street and Number 235 Patapsco Ave.			10f. Zip Code 21222		"	U.S.A.	Country
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-f show int, the Michell Examiliar invatibe notified at	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S.	13. Was Decedent of H II Yes, specify Cubi	Hispanic Origin? (Sp		14. Race - A	merican Indian,
0	r Iter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X		**		Rican, etc.)	Black, W	hitə, ətc. White
9	al', o		3Ã Widowed 4 ☐ Divorced	Year or Dates:		1 □ Yes 24 No	Specify:		Specify:	WILLE
2-0	72 h	Completed by	15. Decedent's Edu (Specify only highest grad	cation le completed)	(0	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	during most of work		b. Kind of Busine	ss/Industry
2	within	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker	u)		Own Hom	e
2	Hygie Hygie ther i	ပ္သ	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma		
an	m - 0 5	To Be	Louis DeLuca				Lucy L	itrenta		
ž	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show ammatic event, the Modical Examinar relation collined at	-	19a. Informant's Name/Relationship (T)	γρ ο , Print)	19b. N	failing Address (Street	and Number or Rui	al Route Number, C	City or Town, State	a, Zip Code)
	and 2 balth a n 27 is		Natale Rao / Son			5 Patapsco				
Š	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery,	risposition (Name of crematory or other pla	ce)		c. Location - City	
Ĕ	Pages iment of tant: If It jury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	MI	eadowr	idge Mem.Pl		-04 E1	kridge,	Md.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licens	XXIO-	+	22. Name and Address Bradley-As	shton-Mat	thews Fun	eral Hom	e, Inc.
	20240		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the c	leath. Do no	2134 William	No. Spring	Rd Parator Ball	to.,Md.	2 12 Approximate
			shock, or heart failure. List only o Immediate Cause (Final							1 / 4
	Physician /Medical		disease or condition resulting in death)	a. Arrythn Due to (of as a con						minuses
	Examiner			HUPOXIA						minutes
:W	D =	if any	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			:				,
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Theirmor						nour
8760,	icate be executed physician and s the burial-transit	E	Tooling in South, 225	Due to (or as a con	isequence or,					
387	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	•	d						
Box 6	leath certifica attending ph I for use as the	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy	·			23d. Date of	delivery
ŏ.	that the death cer ed by the attendir detached for use	Iclai	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 F		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	У		Month	Day Year
P.O.	at the d by the tached	hys	9 Unknown	9□ Unknown				gramma v ma	L	
	The law requires that the site has been signed by thoage 2 should be detache		Part II. Other significant conditions co	ntributing to death but not	- /	11) .	23e. Did toba		to the cause of death? Probably 4 Unknown
ord	een s	Completed by	LET / 7/BILL JVG	accere, a	7, 00	wous Third	11110515			
ec	has b	npie						24a. Was an autopsy performe	24b. Were prior	autopsy findings available to completion of cause of ?
a F								1 ☐ Yes 2 🛭	ZNo 1□Y	es 2□ No
ΖË	ysician: The is certificate hi director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outp	atient 3 DOA Oth	hor	th <i>(Ch</i> ec <i>k only one)</i> ome 5 ☐ Residen	ce 6 DOther /S	inecifu)
of	Attending Physician: r death. ector: After this certifica	\vdash	27. Manper of Death	28a. Date of Injury	28b. Tir	ne of 28c. Inju		28d. Describe how		роспу
ion	nding ath. r: Afte e fund	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	tr) Inji	M 1	Yes 2 □No			
Division of Vital Records,	or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, larn	n, street, lactory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
Ö	ital or irs afte ral Dir	Cer		1						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical		ysicien: To the best of my iner: On the basis of exar						
	To the within 2 To the complet	Med	29b. Signature and titled artifier	and manner stated.		29c. Licen	se number	290	f. Date signed (Mo	onth, Day, Year)
)	8 ∓ ۶ ∓		1,115	1	n)	200	438	3 //	· vember	1.2004
			30. Name and address of person who 8	completed cause of deat	(Item 23a) (T	ype, Print)			- v-r-vinc V	1
			filliam Greens	L 5505 11	rkins	Bayview (Civile B	altrinova	CMP 2	11224
展		ate	31. Date liled (Month, Day, Year)	32. fégistrar's S	ignature	South!				
	Regist	rar	NOV 0 5 29	1U4 ARBANS	A 15 8	1				

			1 - For State Registr AMEND ITEM #	State of Maryland / De 8&29d PER ME G837	partment of Health ar e lthibaeOf DU ath	nd Mental Hygie	2004 35145	5
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death	_
	Physici /Medic		KIETA JERMA	AIN SMITH		October	29, 2004 0415 A M	A
)	Examir		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of I	Death	4c. County of Death	
			Shock Trauma	7 And the same least birther	Baltimore Baltimore Baltimore Baltimore Baltimore	Hrs. Lo. B. L. (Bish	NIA	
	Funeral Director			7. Age (In yrs. last birthdom) 23 Yrs	Mantha Dava Hours	Min. (Month. Day. Y	(ear) 9. Birthplace (State or Foreig	ın
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits	s
	Mary Ff sh	tor	MD N/A	BALT	IMORE		1 (∑Yes 2 □ No	0
	or 28e	irec	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?	
	ath wi	Funeral Director	4815 MELBOUR		21229		U.S. 4.	
	er des	nne		Armed Forces?	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 	n? (Specify Yes or No- Puerto Rican, etc.)	 Race - American Indian, Black, White, etc. 	
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 St. No Specify:		Specify: BLACK	
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "neturel", or Items 23e or 28e-f show event, the Modical Exerting Items at the modified at	ted	15. Decedent's Educ		cedent's Usual Occupation	, 16	6b. Kind of Business/Industry	_
2	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ive kind of work done during most o DO NOT use retired) C. M. A. C. M.	i working	RETAIL	
	Hed w Hygier her th	Co	17. Father's Name (First, Middle, Last)	NA	SALESMAN	T.A. (5) 14:22: 14		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neturel; or Items 23e or 28e-f show any injury or other treumatic event, It's Modical Extending a state of the notified at ODGs.	To Be	EXCELL SMITH		0 1 0	Mane (First, Middle, Ma	EC.ATOR	
ary	should and Men s marke umatic	}	19a. Informant's Name/Relationship (Type	pe, Print) 19b. M	ailing Address (Street and Number o	or Rural Route Number, C	City or Town, State, Zip Code)	
	and 2 ealth a n 27 ls		RITA C. HOLMES/	AUNT 485	5 MELBOURNE	RD. BALTI	MORE, MD 21229	
altimore,	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		sposition (Name of crematory or other place)	i /	C. Location - City or Town, State	
<u>=</u>	it. Partimentitient:		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Fureral Service License	MT.		.04.64 7	BALTIMORE, MD	_
Ba	permit. Departr Importe any inje		Range Constitution of Futbolish Service License		22. Name and Address of Facility VAUGHN C. Green	LE FUNGEAL	SERVICES IKE BALTO, MD 21229	2
	- ×		23a. Part1. Enter the disease, or complishock, or cean failure. List only on	cations that caused the death. Do not				_
	Physician		Immediate Cause (Final disease or condition	. 1 1 / - 1	asher wands		Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as a consequence of):	mon www.			_
	Examiner	_	Sequentially list conditions,	Ducto (or one of)				
	ted nsit	nine	if any, leading to immediate cause. Enter chack ying Cause (Disease or injury	Due to (or as a consequence of):				
Ć	execu in and ial-tra	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dicai	d					
9	ertifica ing ph e as t	a)	IF FEMALE:					
Вох	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy		23d. Date of delivery Month Day Year	- 1
o.	that the death certifi ed by the attending I detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			
<u>s</u>	es that igned b be deta	by Pr	Part II. Other significant conditions con	tributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?	
ğ	S D					1 □ Yes	2 No 3 Probably 4 Unknown	1
Record	ne law requ n has been ge 2 shoul	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	3
		Con				performe 1 Yes 2	d? death? No types 2□No	
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	Other	Death (Check only one)	. —	_
ō		-	1X Yes 2 No '' 27. Manner of Death	28a. Date of Injury 28b. Time	e of 28c. Injury at	ng Home 5 Residence 28d. Describe how		-
<u>o</u>	Attending r death. sctor: After by the funer	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injur	y Work? 1 □ Yes 2 No	SURTECT	was shot	
Division	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f Location (Street	et and Number or Rural Route Number, State) North Cold Route	Π
	ospitel o hours aft unere! Di			street		Dattino	VE, NID	
	24 P. F.	edicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of my knowledge, determined the basis of examination and/or and manner stated.	eath occurred at the time, date and printer investigation, in my opinion, death	place, and due to the caus occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifie	1	29c. License number	29d.	. Date signed (Month, Day, Year)	-
	->-0			WIL	O.C.M.E.	Oc	tober 30 , 2004	
	1		30. Name and address of person ho co		pe, Print)			7
		-1	JACK M. 1	TWS M.D.	111 Penn Street,	Baltimore,	Maryland 21201	_
	Sta Registr		NOV 0 5 2004	32/Registrar's Signature	Sports			

State Registrar 31. Date filed (Month, Day, Year) NOV 0 5 2004

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

IN

acks

29c. License number

OCME

29d. Date signed (Month, Day, Year)

October 29, 2004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2014 35147 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov. 3, Physician 2004 8:00am William Joseph Shue III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel 1682 Crownsville Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. June 30, 1957 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1**⊠**M 2□F 47 Maryland 217-66-2524 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County d other than "naturel", or items 23s or 28e-f show event, the Medical Examiner must be notified at 1 Yes 2 No Directo MD Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21401 1682 Crownsville Rd 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or item any injury or other treumatic event, the Medical Exerter-1 Yes ZZNo f Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes ※ No Specify: white δ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crown Station Gas station attendant 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be ပ Barbara V. Knight William Joseph Shue Jr. 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Joseph Shue Jr. Father B01 Newfield Rd. Gen Burnie, Maryland 21061 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Balt Thore Crematory 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) @ Loudon Park Nov. 5, 2004 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service icensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Rant1. Enter the disease, or complications that caused the shock, or heart failure. List only one caused neach line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 3 200 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 esidence 6 □Other (Specify) 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: Af
d in by the fur 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

10

31. Date filed (Month, Day, Year) NOV 0 5 2004

Name and address

32. Registrar's Signature

6 Sports

State of Maryland / Department of Health and Mental Hygien 2004 35148 1 - For State Ragistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Joyce Elaine Sargent 2, November 2004 6:29 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Days 1□M 2XF Hours Min. 68 Yrs. Director 220-20-7184 Delware 17, 1936 Usual Residence of Decedent with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20794 7810 Clark Road C-25 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after of death and Mental Hygiene. om 27 Is marked other than "natural", or Ites 1 Never Married 3/ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 200 No 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Edward Kimmey Leona May Webb ပ 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health an.
Important: If I ten 27 is m. any Injury or other 2. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Sargent/Husband 7810 Clark Road C-25, Jessup, MD 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov 3 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2004 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licensee ²² Name and Address of Facility. Cremation and Funeral Alternatives 8717 Green Pastures Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Tary Isading to in radic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit wer Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy \$\int_\text{Live birth} 2 \subseteq \text{Fetal death} 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Month Y*e*ar 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? intestind this certificate 2 🗆 No 1 ☐ Yes 2 No 1 Tyes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 1)25205 nthan e und 30. Name and address of person who concleted cause of de 111 tem 23a) (Type, Print) 6601 N. Charles Street Towson, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

NOVEM RAR

SARGENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death Reg. No. 2004 3514
	Dhusiair		1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death
4	Physicia /Medic		75ABellA . C. DINGER NOV 3 2004 1:20-
1	Examin	er	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death
			MANCE CARE NURSING HOME (ROSSVITE) ROSERALE BALTIMORE 5. Social Security Number 6 Sex 7 Age 1/10 yrs last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birtholace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 214-01-2740 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) MARCH 17.1914 9. Birthplace (State or Foreign Country) MARCH 17.1914
	Director		Usual Residence of Decedent
9	Manage Ma		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
2	Mary Park	ģ	MD BALTIMERE PERRY HALL
1	23	<u>s</u>	10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?
1	38 M	alD	1 = Morec. CI. 21236 U.S.A.
7		ner	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
2	a de la la la la la la la la la la la la la	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify:
00		Đ Q	Year or Dates:
15 E	i i	Be Completed	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
112	then.	E C	Elementary/Secondary (0-12) College (1-40r 5+) NA CLERK PAPER CORP.
9	Hygi d	ပို	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
lan	ked o	To B	UNKNOWN
Maryland 21215-0020	end Mentel Hygi s marked other sumetic event,	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	27 is		William Singer 15 Morec CI. Batto Ms 21236
e d	of Health of Health fitem 27 r other tr	1	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stata
E S	nt: #		4 Donation 5 Demer (Specify) PATCONDER LORRAINNE PARK Cem 118/64 Lander M.D.
Baltimore,	Johns. Tages I and 2 should be lied within 72 no Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical DICE.	1	21. Signature Funeral Service Licensee 22. Name and Address of Facility 12. Name and Address of Facility 14. Name and Address of Facility 15. Name and Address of Facility 16. Name and Address of Facility
m a	impo gany ence		Well M Stells 7527 HARFORD RD. BAITO, ND 21234
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
P	hysician		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition) Moto static Cum phoma
A\$	xaminer		resulting in death) Due to (or as a consequence of):
3	sit ed	Examiner	b
	physician and s the bunal-trensit	xan	Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Einer Underlying
9	sician		Cause (Disease or injury c.
68760,	ing physe es the	Medical	resulting in death) Last Due to (or es e consequence of):
Records, P.O. Box 68760,	attending I for use 6		d
. §	igned by the attendibe detached for use	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death
P.0	by the	Ph.	1 Yes 2 No 3 Probably Aprilanow
6	pe de de	∣ਨੂ	
ord	been si should	Completed	Diabltes Wellitus 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause
ec ec	has b	n p	of death?
		Ö	1 Vec 20 No 1 □ Yes 2 □ No
of Vital Records,	s certificate hadinector, page	Be	25. Was case referred to medical examiner? 1
to a		2	1 Inpatient 2 EH/Outpatient 3 DOA Nursing Home 5 Hesidence 6 Dother (Specify)
o F	Afte Tune		27. Menner of Death Contact 28e. Date of Injury 28b. Time o
Division	after death. Director: A	fica	3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
á	s after	Certification:	4 ☐ Homicide building, etc. (Specify) City or Town, State)
iO Di	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Sai	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [2] Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
1	in 24 the Fi	edicai	one) and manner stated.
J.	5 × 6 0	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	0		1 villaum, 40 056479 1114/04
	1,8	ŀ	30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Nordo: Phyrothy 7845 Dalcuston 0 RA Ste 100 Coley Runnie MA
1	Ct-c		Madai Chardon 7845 Dalcword Vs Ste 100 Colon Burn if 40 31. Date filed (Month, Day, Year) 32. Registrer's Signature
	Stat Registra		NOV 0 5 2004 No
DHMI	H 16 Rev 6/95		Deneva & Sparks

ORIGINAL

			1- State of Maryland / Dep	artment of Health and Me	ntal Hygien	2004 35150
			1. Decedent's Name (First, Middle, Last)	2.	Date of Death	3. Time of Death
я	Physicia /Medic		ROY SAMUEL SPRINKLE	No	Month Da	ау, 2004 4:40 а м
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
		•	Calvert Mem Hosp. Transitional Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Prince Frederick	Date of Birth	Calvert
	Funeral Director		500-38-0186 1X M 2 F 67 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year OV 29, 19	9. Birthplace (State or Foreign Country) Missouri
	D		Usual Residence of Decedent			
	Aaryla I shov	ō	Maryland Anne Arundel 10c. City, Town or L Baltimo			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-i	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	filed within 72 hours after death with the Maryland Hygiene ther then Insturel; or Items 23a or 28a-f show ant, the Marical Examiner must be notified a		146 West Edgevale Road	21225		USA
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13.	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
36	irs afte		1 □ Never Married 2 □ Married 1 X Yes 2 □ No 3 X Wildowed 4 □ Divorced Year of Dates: Korea	1 ☐ Yes 2 No Specify:		Specify: White
9	72 hou	Completed by	15. Decedent's Education 16a. Dece	edent's Usual Occupation a kind of work done during most of working	16b. I	Kind of Business/Industry
21	ithin 7	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Laborer
2	filed w Hygiel ther tl	CO	Unknown Ware 17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maide	
Maryland 21215-0036	uld be Mental Irkad o	To Be	Roy Sprinkle	Daisy Ma		,
Mar	12 sho h and I 7 Is me traume		- · · · - · · · · · · · · · · · · · · ·	ing Address (Street and Number or Rural R		
ē,	1 and Health tem 2		20a. Method of Disposition 20b. Place of Disp	West Edgevale Rd.,		e, Ma. 21225 Location - City or Town, State
ē	Pagas nent of l ant: If its arry or o		1 Burial 2 Cremation 3 Removal from State Bayview (Crematory, Inc. 11/5	,2004 Ba	ltimore, Maryland
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28a-f show amportent: If item 27 is marked other than an interest or items and the nutilised at once.			12. Name and Address of Facility 1. Name and Address of Pacility		
				237 E. Patapsco Ave. nter the mode of dying, such as cardiac or re	Balto.	
0	Pnysician _i		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Interval Between Onset and Death 3 Weeks
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	CXAIIIIIei	_	Sequentially list conditions frank, leading to immediate Due to (or as a consequence of):	nic Obstructive A	irway c	disease
7	uted d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
,092	te be executed ysician and ie burial-transit		resulting in death) Last Due to (or as a consequence of):			
9289	ificate be executed g physician and as the burial-transit	dlcal	d		<u> </u>	
9 X C	certifi nding use as	by Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
œ.	death e atte	sicla	in the past 12 movins? 1 Yes 2 No 1 Yes 2 No	□Ectopic pregnancy □ Other (specify)		Month Day Year
<u>о</u>	at the d by th etache	Phys	9 Unknown		22a Did tabaasa	use contribute to the cause of death?
Vital Records, P.O. Box	signer d be d	d by	Part II. Other significant conditions contributing to death but not resulting in the the Hypoxia due to Chronic 13es			2 ☐ No 3 ☐ Probably 4 ☐ Unknown
CO	s been shou	Completed	Sejaure disorder		24a. Was an	24b. Were autopsy findings available
- Be	The la ate ha	mo	Uninary treet infection		autopsy performed? 1 ☐ Yes 2 ☐ N	prior to completion of cause of death?
/ita	cian: ertifica ector,	Be (25. Was case referred to medical	26. Place of Death (C		
of	Physi this o	- To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		5 Residence	6 ☐Other (Specify)
Division of	nding tth. : After e fune	atlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work? M 1 □ Yes 2 □ No	,	,
N N	r Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office 28f	Location (Street a City or Town, Stat	nd Number or Rural Route Number,
	ortal o					
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and nestigation, in my opinion, death occurred	at the time, date an	s) and manner as stated. Indicate place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier Grand. C. Furana.	29c. License number		ate signed (Month, Day, Year)
)			4	D 50653		1-2-2004.
	411		30. Name and address of person who completed cause of death (Item 23a) (Type 5851 Deale Church Ro	Print) GYAN. C. SL		
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature		<i>y</i> 00	1-11
	Registr	ar	NOV 0 5 2004 Genera &	boals		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2001 35151 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day October 30, Eileen Cecilia Selby 2004 9:20 A^{M} 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7436 Berkshire Rd. Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/21/1939 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F 64 216-36-9887 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7436 Berkshire Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietary Clerk 11 Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecilia Poremski Joseph Nevedale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7436 Berkshire Rd. Baltimore, MD. 21224 James E. Selby (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 11/02/2004 Towson, MD. 21. Signature of Funeral Serv 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, MD. 21222 Dundalk, Inc. 23a. Part Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final disease or condition resulting in death) Ocan Dicit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13/6960 November 1,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. E. Chatham, M.D. Balto., Md. 21222 1576 Merritt Blvd., Suite 14

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Registrar

Physician

/Medical

Examiner

Director

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Completed

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Certification: To

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7 is marked other then "neturel", or items 23e or 28e-f show treumatic event, the Madical Examiner is less to inflied at

permit. Pages 1 and 2 should be filed within 72 hours atter to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or iten eny injury or other treumetic event, the Medical Examinations.

Priysician /Medical **Examiner**

use as the burial-transi

signed by the attending physician I be detached for use as the buria

this certificate !

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics

Division of Vital Records, P.O. Box 68760

and

Baltimore, Maryland 21215-0036

the Maryland

death with

31. Date filed (Month, Day, Year)

32. Registrar's Signature NOV 0 5 2004

DHMH 17 Rev 1/2001

1 - State Registral I. Decedent's Name (First, Middle, Last)

DOHN

5. Social Security Number

GEORGE

4a. Facility Name (If not institution, give street and number)
VA Baltimore Medical Center

SOELLNER

7. Age (In yrs. last birthday)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieze 0 [4 35152 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death october

4b. City, Town, or Location of Death

Ka-1timore

8:56 PM

1 Yes 2 □ No

Approximate Interval Between Onset and Death

WEEK

Year

04

4c. County of Death

N/A

Physician
/Medical
Examiner

Funeral Director

Soellner

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, or Items 23a or 28a-f show "naturel" Department of Health and Mental Hyglene. Importent: If item 27 Is marked other than " injury

aryland 21215-0036

Physician /Medical Examiner

burial-transit the P.O. Records. Division of Vital To the Hospitel or Attending Physicien: this After death. Director:

 Birthplace (State or Foreign Country) 1 M 2□ F 212-32-2252 69 Mary land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5624 Laurelton Avenue 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Bethlehem Steel Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Soellner Barbara Mav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Soellner - Wife 5624 Laurelton Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Hilltop Service Corp. 11/3/04 Towson, Maryland 21. Signature of Funeral Service Licensee) 22. Name and Address of Facility Heather Cain Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIA Due to (or as a consequence of): Sequentially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did jobacco use contribute to the cause of death? 1 d Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26 Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 No 1 🗹 Inpatient 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P015881 04 10/30 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

State

ANDREW OSUEl

NOV 0 5 2004

31. Date filed (Month, Day, Year)

within 24 hours a To the Funerel D

BACTIMORE

10 N. GLEENE

32. Registrar's Signature

MD

		Please Type or Prin State of Ma 1 - State Registrar	aryland / Depa		lealth and Me	•	າຣີ ກຸກ ໄ	35153
Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) WERNER W . STITH 4a. Facility Name (If not institution, give street and number)		4b. City, Town, c		Novembe	Day Year V 1 2004 4c. County of Death	
Funeral Director			Baltinicare o (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye 7-9-1945	N/A 9. Birth Cot VIR	aplace (State or Foreign intry) GINIA
the Maryland 28a-f ehow	rector	10a. State 10b. County MD • N/A	10c. City, Town or Lo			10g.	Citizen of What Cou	10d. Inside City Limits 1 X Yes 2 □ No
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene Hygiene "natural", or tems 23a or 28a-f show ent, tre Medical Exertine must be notified at	Completed by Funeral Director	2038 N. BENTALOU ST. 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent I Armed Forces? 1 Yes, Give 15 Yes, Give 16 Yes, Give 17 Year or Dates:	10	21216 Was Decedent of F	dispanic Origin? (Specan, Mexican, Puerto R	sify Yes or No-	USA 14. Race - Amer Black, White Specify: BLA	ican Indian, , etc.
21215-0036 od within 72 hours aff gjene. of than "naturel; or tra Medical Exerti	ompieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -11- -0-	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	9	Kind of Business/li	
Maryland	To Be C	17. Father's Name (First, Middle, Last) EDWARD STITH 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	18. Mother's Name MILLIE and Number or Rural	CABINESS		ip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumetic event, the Medical Exercites must be notified at any injury or other traumetic avent, the Medical Exercites must be notified at any once.		SHIRLEY STITH(SISTER) 20a. Method of Disposition 11 Burial 2 of femation 3 Removal from State 4 Donation 5 of her (Specify) 21. Signature of heral Service Censes 11 April A	20b. Place of Dispo cemetery, cres	osition (Name of matory or other pla MEMORIAL	PARK 11-6-	20c -2004 BA	LTIMORE,	own, State MARYLAND
Fnysician /Medical Examiner		23a. Part 1. Exter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) a	the death. Do not en	ter the mode of dyin			ORE, MARY	LAND 21217 Approximate Interval Between Onset and Death
3 (60), ate be executed hysician and he burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events c.	a consequence of):	Can	CEP			
that the death certificate led by the attending physic detached for use as the let	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of delive Month	very Day Year
RECORDS, P.O The law requires that the le has been signed by the age 2 should be detache.	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tobacc		bably 4 4 Triknown
age h	e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performed 1 Yes 2 12	? prior to co	opsy findings available ompletion of cause of
Phys Phys	Certification: To B	examiner? 1 Yes 2 No 27. Mann- of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide Hospital: 1 Inpatie: (Month, Da.) 28a. Date of Injuicide (Month, Da.) 28b. Place of Injuiciding, etc.	y Year) 28b. Time of Injury	of 28c. Injui Wor M 1	ry at rk? Yes 2 \(\square\) No	8d. Describe how in	and Number or Rui	
DIVISION Physpital or Attending 24 hours atter death. Fineral Director: After	edical Cert	29a. Certifier (Check only one) 1 Certifying Physician: To the best only one) 2 Medicel Examiner: On the basis of and manner sta	of my knowledge, deat f examination and/or in	th occurred at the tile	me, date and place, ar	nd due to the cause	e(s) and manner as	stated. to the cause(s)
To the Hg within 24 To the F	Me	29b. Signature and Little of certifier Address M. Brul	M.O.	1.74	5 4 4 8 2		Date signed (Month	
	ate	30. Name and dr of person who completed cause of d 1) r Patrick McGinley M. D 31. Date filed (Month, Day, Year) 32. Registr	2401 L	Perint) Ves & Belve Sparks	edere Ave	Balti	more, MD	
Regist	rar	NOV 0 5 2004	~ /~ /	1				

	1 - For State Registrar	State of Maryland /	Department of H Certificate of L	eaith and Mental Death	Hygiene 004	35154
Physician /Medical	Decedent's Name (First, Middle, La	st) ARA	TAUB		of Death MBER 2, 2004	3. Time of Death 7:00 P M
Examiner	4a. Facility Name (If not institution, giv JEWISH CONVALESC	· ·	4b. City, Town, or BALTIMO		4c. County of De BALTII	
Funeral Director	1 1 1 1 1 1 1	For Total Page (In yrs. last b)	irthday) If Under 1 Year Months Days	Hours Min. 8. Date	of Birth 9. Bi	nthplace (State or Foreign ountry) UKRAINE
Aaryland I show	Usual Residence of Decedent 10a. State 10b. County MD B		wn or Location			10d. Inside City Limits 1 ☐ Yes 2 🏋 No
with the has or 28e-	10e. Street and Number 1333 KATESWOOD R		10f. Zip Code	21209	10g. Citizen of What C	ountry?
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23a or 28e-1 show other treumetic event, the Medical Examinar rust be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 M Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🏋 No	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, etc Specify:	or No- 14. Race - Am Black, Wh Specify:	erican Indian,
Maryland 21215-0036 ad 2 should be itled within 72 hours at lith and Mental Hygiene. 27 Is marked other then "neturel; or riteumetic event, the Michal Exam To Be Completed by F	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired,	furing most of working	0WN HOME	s/Industry
yland 2 Juld be filed Mental Hygis arked other ettic event, II To Be Cc	17. Father's Name (First, Middle, Last BARUCH)	GUTGARTZ	18. Mother's Name (First, M		BLANK
y, Maryla and 2 should and 2 should and Men n 27 is marke er treumetic	19a. Informant's Name/Relationship (BAND 1	1333 KATESWOO	D ROAD - BALT	Number, City or Town, State, TIMORE, MD 21.	
000-	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci	Removal from State BALTIN		EM. 11/4/2004		ΓΟWN, MD
Baltime permit. Pag Department Importent: I eny injury o	21. Signature of Funeral Service Lice	Trom	8900 REIST	ERSTOWN ROAD	/INSON & BROS - PIKESVILLE	, MD 21208
Pnysician /Medical Examiner	23a. Par11. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do one cause on each line. ALZHEIMERS [Due to (or as a consequence	DISEASE	g, such as cardiac or respirat	tory arrest,	Approximate Interval Between Onset and Death 4 YEARS
<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence	o of):			
376 ate be nysicia he bu	resulting in death) Last	Due to (or as a consequence	of):			
Records, P.O. Box 68 The law requires that the death certifics the has been signed by the attending ph age 2 should be detached for use as it completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕅 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify) □		23d. Date of de Month	olivery Day Year
cords, P. wrequires that been signed by should be deta	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause give	en in Part I. 23e.	Did tobacco use contribute	o the cause of death?
					autopsy prior to performed? death?	utopsy findings available completion of cause of s 2 No
of Vital F hysicien: Th his certificate I director, pag	25. Was case referred to medical examiner? 1 ☐ Yes 2 [¾] No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA Othe	26. Place of Death (Check of St. 4) Nursing Home 5	only one) Residence 6	ecify)
Division of Vita To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director. Medical Certification: To Be C	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)		rat 28d. Desc ?? Yes 2 □ No	cribe how injury occurred	
Division or attentions after death hours after death unered Director: y filled in by the sal Certification.	4 Homicide determined	building, etc. (Specify)		City o	tion (Street and Number or F or Town, State)	
the Hospite in 24 hours the Funerel pletely filled edical C	29a. Certifier 1 🔀 Certifying P (Check only one)	hysician: To the best of my knowledg miner: On the basis of examination a and manner stated.	nd/or investigation, in my op	ie, date and place, and due to pinion, death occurred at the	time, date and place, and du	s stated. e to the cause(s)
To the within 2 To the complete	29b. Signature and title of centifier	she MD	29c. License	D15140	29d. Date signed (Mon	
3	30. Name and address of person who	completed cause of fleath (Item 23a) 1.D 6210 PARK I	(Type, Print) HEIGHTS AVENU	JE - BALTIMORE	E, MD 21215	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	· · · · · ·			
DHMH 17 Rev 1/2001	NOV 0 5 2004	Serwa &	GINAL			

			For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of Hertificate of D	ealth and Death	Mental Hyg	gien20(35155
	Physicia	an	1. Decedent's Name (First, Middle, Last)	v Lee	ДОГ	zyk		2. Date of Dea Month	Day	3. Time of Death
	/Medic	al	Stanle 4a. Facility Name (If not institution, give st	4	162	4b. City, Town, or	Location of Dea		2 31, 2	
	Examin	er	6815 Boston Avenu			Dunda				timore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		If Under 24 Hr. Hours Mir	(Month, Day	h (, Year)	Birthplace (State or Foreign Country)
	Director		213-32-0411	M 2□F 68	8 Yrs.	World Days	110010	Dec. 2	1,1935	New Jersey
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	Mary 8-1 sh	tor	Maryland Baltin	nore			Dund	lalk		1 ☐ Yes 2 🛣 No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
	s 23a	ral	6815 Boston Avenue		:-IIC 12.1	Man Danidan of His	21222	Canada Van an Na	United	States e - American Indian,
326	be filed within 72 hours after death with the Maryland Hygiene. d other than "naturel", or items 23a or 28e-f show event, the Medical Evairing from the profilled at	by Funeral	11. Marital Status 1 Never Married	 Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	Specify:	rto Rican, etc.)	Blace Specify	ck, White, etc.
Ö	72 hou	ted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occupa	tion	orking	16b. Kind of Bu	usiness/Industry
21	ithin 7 ne. Ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d DO NOT use retired)	uning most or w	DIKING		
2	a filed within 72 h I Hygiene. other than "naturent, the Neulica		10 Years 17. Father's Name (First, Middle, Last)		Ins	ulator	18 Mother's Na	ame (First, Middle,	LOCa	
Maryland 21215-0036	2 should ba f and Mental h Is marked of raumatic eve	To Be	Stanley A. Tezyk					nces J. H		
ary Z	shoul ind Mi	۳	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailir	ng Address (Street a				
	1 and 2 Health a tem 27 is		Mrs. Kathleen Dani	ecki/Daugh		Glen Kel	d Ct.	Baldwin,	Maryla	nd 21013
altimore,	Pages 1: nent of He int: If Iten iry or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date	20c. Location -	City or Town, State
Ħ	t. Pag rtment rtant: njury		 4 □ Donation 5 □ Other (Specify) 21. Signature J Funeral Service License 		Oak Lawn	Cemetery Name and Address	11/4/2	2004	Balt	imore, MD
Ba	permit. Pages 1 and 2 should by Opparament of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.	1	21. Signaturi Punerai Service License	09	Du	ıda-Ruck E	uneral			
			23a. Part 1. Enter the disease, or complice shock, or heart vailure. List only one	ations that caused the	ne death. Do not ent	22 Wise A er the mode of dying	ve Du , such as cardia	ac or respiratory ar	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	mesi		a				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					
	LAGIIIIII	<u></u>	Sequentially list conditions, b.	Due to (or as a	consequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events							
oʻ	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
8760,	ate be hysici the bu	dical	d.							
9 X	cartific iding p	/Me	IF FEMALE: 23	3c. If yes, outcome of	pregnancy				23d Dat	e of delivery
Вох	that the death cartificed by the attending properties detached for usa as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at tin		Ectopic pregnancy Other (specify)			Mor	
P.O.	by the	hys	9 Unknown	9□ Unknown						
Records, I	sign sign d be	þ	Part II. Other significant conditions conf	ributing to death but	not resulting in the u	nderlying cause give	n in Part I.	23e. Did to	-	ibute to the cause of death? 3 Probably 4 Unknown
ecc	ne taw requ n has been ge 2 shoul	Completed						24a. Was a	sy p	Nere autopsy findings available prior to completion of cause of
		Con						perfor 1 🗆 Yes	med? c 2 No 1	death?
Vita	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	ospital:	• CT 57:0	Othe	r	eath (Check only or		
ō	Attending Physician: sr death. ector: After this certific: by the funeral director,	-	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	28b. Time of	f 28c. Injury	at Nursing	Home 5 ✓ Resid 28d. Describe h		
ion	utending I death. ctor: After / the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(ear) Injury	Work M 1□Y	es 2 No			
Division of	i Sitte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct complately filled in by	edical C	29a. Certifier (Check only one) 15 Certifying Phys 2 Medical Examin	ician: To the best of e er: On the basis of e and manner state	xamination and/or in-	n occurred at the time vestigation, in my op	e, date and place inion, death occ	e, and due to the courred at the time, of	ause(s) and ma late and place, a	nner as stated. and due to the cause(s)
	To th within To th compi	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed	(Month, Day, Year)
	/		I My M)			V^{T}	848/		11/2/	07
	9		30. Name and address of person who cor	3114 S	AND PIPE	Print) R CIRC	(G) 1	BALTO, A	4021	236
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 5 2004	22. Registrar's	s Signature	loads				_

State of Maryland / Department of Health and Mental Hygien 001	
2004	

			For State Registrar	State of Man	yland / Dep <i>Ce</i>	artment of H rtificate of I	lealth and N Death		ien2004	35156
	Physici	an	1. Decedent's Name (First, Middle, La	,		The seemed as	_	2. Oate of Deat Month OCTODET	Dav Year	3. Time of Death
	/Medic Examin		Christoph 4a. Facility Name (If not institution, giv			Thornton Octo 4b. City, Town, or Location of Death			Ober 30, 2004 10:50 P M	
	LXdIIIII		Jniversity of Mary	,	l Center	Baltin			N/A	
	Funeral Director		220-33-3764	Sex 7. Age (// ★ M 2□F 19	n yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05-17-19	Year) 9. Birth Cou 985 Virg	place (State or Foreign intry) 1 N 1 a
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation			T	10d. Inside City Limits
	Mary e-f eh	tor	Maryland Carrol		Moun	t Airy				1 ☐ Yes 2 🛛 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	s 23a		93 Meadowlark Av	/enue 12. Was Decedent Eve	u in II 6 42	21771	· · · · · · · · · · · · · · · · ·		USA	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 ie marked other then "naturel", or items 23a or 28e-f ehow or other traumatic event, If a Medical Exactine traumatic event.	by Funeral	11. Marital Status 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2X□ No If Yes, Give Year or Dates:	F #1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	14. Race - Ameri Black, White Specify:Whit	, etc.
5-0	72 ho 'natur	eted	15. Decedent's E	ducation ade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of Business/fr	idustry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired < Lift Ope			Nuxcoxy	,
d 2	e filed within al Hygiene. other then '	Be Co	17. Father's Name (First, Middle, Last,)	1011	· Liit ope	18. Mother's Name	e (First, Middle, N	Nursery Maiden Sumame)	
ylar	should be nd Mental marked o	To B	William L.	Norman			Dana		Thornton	
Maryland	2 shour and M		19a. Informant's Name/Relationship (,	19b. Maili	ng Address (Street a	and Number or Run	al Route Number,	City or Town, State, Zi	Code)
	1 and 1 Health tem 27		William L. 20a. Method of Disposition	Norman	153 20b. Place of Dispo	Lecox Ct osition (Name of	3		7295 20c. Location - City or T	own, State
altimore,	Pages ient of nt: If i		1)☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	Removal from State		matory or other place Cemetery	1		Rockwell. N	
Balti	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Liber	1		2. Name and Addres	ss of Facility S	tallings	Funeral Ho ena MD 2112	me P.A.
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a/	Multiple	Injune	25			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequencé of):	J				
	26	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsaquenta orj.					
	acuted nd transit	Examiner	that initiated events	c						
60,	be exe ician a burial-		resulting in death) Last	Due to (or as a co	onsequence of):					
68760,	ficate be executed physician and is the burial-transit	edlcal		d			,			
.O. Box	that the death certifiined by the attending I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ery Day Year
Vital Records, P.	8 50	by	Part II. Other significant conditions of	contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to to	he cause of death?
900	e law requir has been si je 2 should b	Completed						24a. Was an		psy findings available
Ž	iù -	Com						perform	ned? death? □ No 1 Yes	mpletion of cause of 2 No
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			
of	Physic this aral dis	≥: To	1X Yes 2 □ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier	f 28c. Injury	at	me 5 Resider 28d. Describe hor	nce 6 Other (Specification of the following occurred)	r)
on	Attending I r death. ector: After by the funer	atlor	1 □Natural 5 □ Pending 2 △Accident investigation	Month, Day Ye	ear) Injury	Work	k? Yes 2∭XNo	1 3 4	n struck by	motor vehicle
Division	i or Attendater deatl Director:	Certifications	3 Suicide 6 Could not b		At home, farm, str	reet, factory, office		28f Location /Ctr	eet and Number or Rura State) Pt 27 St	I Pouta Number
	pitei o urs afi srel Di			1	street			senter 51.	MITATINY, MD	
	To the Hospitei or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar	nysician: To the best of miner: On the basis of example and manner stated	amination and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as s ite and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month,	Day, Year)
			Pamety Sou	thall mo		0.	C.M.E.	00	ctober 31,	2004
			30. Name and address of person who Pamela B. South				reet, Bal	ltimore,	Maryland 2	1201
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 0 5 2	32. Redistrar's	Signature	book				

		-	For State Ragistrar		artment of Health and rtificate of Death	Mental Hygier	_ , ,	35157
			Hagistrar 1. Decedent's Name (First, Middle, Last)		, in out of Double	2. Date of Death		3. Time of Death
	Physicia /Medic		EMMA J. TAYLOR				31, 2004	11:15a M
	Examin		4a. Facility Name (If not institution, give street and r	number)	4b. City, Town, or Location of Death 4c. County of Death			h
			MANORCARE NURSING CENT		BALTIMORE		N/A	
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 CXF	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir	. (Month, Day, Yea	ar) 9. Birth	nplace (State or Foreign untry)
	Director		225-56-6964 Usual Residence of Decedent	60		9-12-19	44 V1	RGINIA
	land	Ì	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Many First	ţō	MD. N/A	BALTIMO	RE			1 X Yes 2 No
	h the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?
	11 will	ai D	3347 W. BELVEDERE AVE		21216		USA	
	r dea	Funerai	Amed		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
3	filed within 72 hours after death with the Maryland Hygiene Hygiene than "naturel", or Itams 23a or 28a-f show ant, the Marikal Examiner must be multified at	by Fu	Il Yes,	s 2 XNo Give r Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: BL	ACK
	hour tural	ed b	15. Decedent's Education	16a Dece	edent's Usual Occupation	16b	. Kind of Business/l	Industry
2	in 72 n "na	Completed	(Specify only highest grade complete	d) (Give life.	s kind of work done during most of w DO NOT use retired)	orking		
7	yiene r tha	mo:	Elementary/Secondary (0-12) College -120-	' '	ARE PROVIDER		DAYCARE	
2	be file trail Hyg od othe event,	Be C	17. Father's Name (First, Middle, Last) UNKNOW	VN.	18. Mother's Na	ime (First, Middle, Maid	den Sumame)	
<u></u>	should b nd Ments marked matic e	Tof				SMITH		
_	2 should be filed within and Mental Hygiene. Is marked other than raumatic evant, the M		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or F 7 W. BELVEDERE AV			
2	and ealth n 27		VERONICA WHITE (DAUGHT)	20b. Place of Disp			Location - City or	
2	permit. Pages 1 Department of Hi Important: If itar any injury or ott		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 □ Removal Iro	om State cemetery, cre	nmatory or other place)		·	
altillion a	nit. Pa artmer ortant injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee JON		MEMORIAL PARK 11. R Name and Address of Facility P		LTIMORE, ERAL HOME	
ם	permit. Departn Imports any inju		I math OS	V /	721-27 N. MONROE			•
-			23a. Part Enter the disease, or complications that shock, or heart failure. List only one cause of	at caused the death. Do not en	iter the mode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between
۱	Physician	ĵ	Immediate Cause (Final disease or condition	BREAST	CARCINO	OCA		Onset and Death
	/Medical		reculting in death)	to (or as a consequence of):	CARCINO (METAS			
	Examiner	_	Sequentially list conditions, b.	to (or as a consequence of):	CLECKE	(A) (C))	
	led Isit	Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury	to (or as a consequence or).				
	akecu aktrai	Exar	that initiated events c.	to (or as a consequence of):				
0/00,	cate be executed physician and s the burial-transit	dicai	d			- <u>-</u>		
D	# 0 g	Ψ.	IF FEMALE					
Š	death certifi e attending j od for use as	an/N	23b. Was decedent pregnant		□Ectopic pregnancy		23d. Date of deli Month	ivery Day Year
	0 0 2	Physician/M	1 Voc de No	egnant at time of death 5 nknown	Other (specify)			
ŗ	The law requires that the te has been signed by th bage 2 should be detache	Phy	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
S,	uires sign	d by	DIABET	TES		1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
cords	w req	iete	LIVIPER	TEN SIOO	J	24a. Was an		topsy findings available
Ľ	he la e has age 2	Completed	(A) C			autopsy performed 1 Tes 20	l? death?	completion of cause of
VII	sician: Th certificate rector, pag	0	25. Was case referred to medical		26. Place of D	eath (Check only one)		
	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Spec	cify)
10 U	ding Ph J. After th funeral		27. Manner of Death 1 Natural 5 Pending (A	ate of Injury 28b. Time fonth, Day Year) Injury	Work?	28d. Describe how in	njury occurred	
S	tandile eath. or: A the fu	cati	2 Accident investigation	41.	M 1 Yes 2 No	28f. Location (Street	tond Number or Pu	um/ Pouto Number
UNISION	or At after d Diracl in by	Certification:	determined 200. FI	ace of Injury - At home, farm, s uilding, etc. (Specify)	treet, lactory, office	City or Town, Si	tate)	rai noute vuiliber,
_	spital	ai Ce	29a. Certifier Cartifying Physician: To	the best of my knowledge, dea	th occurred at the time, date and pla	ce, and due to the cause	e(s) and manner as	stated.
	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	ledicai		e basis of examination and/or in nanner stated.	nvestigation, in my opinion, death oc			
	To t To t	Σ	29b. Signature and title of certifier	R Q	29c. License number	11 G = 29d.	Date signed (Monti	n, pay, rear)
	1		Marco	-12.000	The state of the s	4664	(1)1	104-
	b		30. Name and address of person who completed of	ause of death (Item 23a) (Type	Print)	108	7 1	715
P	Sta	a to		2. Registrar's Signature	1 1 10 80			
	Regist		NOV 0 5 2004	ena &	Sparks			

URBanski, Genevieue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#24a, perMR, G837, 11/5/04TT

State of Maryland / Department of Health and Mental Hygier 0 0 14 35158 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 35^{PM} Genevieve Urbanski 3 /Medical November 2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Stella Maris at Mercy Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth 0 (Month Pay) 1991 7 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F 216-07-5525 87 Maryland Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f ehow treumetic event, Ite Madical Examiliar mast be notified at Yes 2 No Maryland N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2242 Bank Street 21231 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Schools 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Matthew Piekarski Alexandra Zalewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If item 27 I 2242 Bank Street Baltimore, Maryland 21231 Janis Urbanski - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) S Secretary Trempley of their place injury or Department of Importent: If any injury or once. 11/06/2004 Baltimore, MD Jesus Cemeterv 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Pavid J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, MD 21231 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 attending physician eq Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 19 months? Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 her (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 🗌 Yes this Mospice 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: After or Attending 5 Pending investigation Injury atural death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours eff To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 40857 2004 ed cause of death (Item 23a) (Type, Print) Lischers 21202 1219 301

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 0 0 1 35159 1- State Amend Item 20b-c per fh G837 Der Tille at the Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 15 AM /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DUNDAL UND If Under 24 Hrs. MORI Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 K F Director 212-40-6180 BALTIMORE, MC Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23a or 28e-1 show other treumatic event, the Mcdical Examiner must be notified at 1 Yes 2 No Directo MODE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 KON Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ Specify: 3 ☐ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is meny injury or other treum 2008. STAL 20b. Place of Disposition (Name of Bel Air 20a. Method of Disposition 20c. Location - City
Forest cometery crematory or other place)

Evans Funeral Chape1 1 Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) 11-5-04 21. Signatur of Funeral Service Licensee 1012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** manlly /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examiner be executed use as the burial-transi Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Knknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 215KN0 1 ☐ Yes 2 **X**No Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending within 24 hours after death, To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MYO THANT 8114 SANDPIPER CIRCLE) BACTO, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	laryland / Depa Ce	artment of F	lealth and Death	Mental Hygi	eng 0 0 4	35160		
	Dhoraini		1. Decedent's Name (First, Middle, I	.ast)				2. Date of Death Month	Day Yea	3. Time of Death		
	Physici /Medic		Ruth Lee Van 1	Rensselaer				November	2, 2004	3:06 PM ^M		
	Examir		4a. Facility Name (If not institution, g		7)	4b. City, Town, o	r Location of Deal	th	4c. County of De	eath		
			813 Marcie Cou				. Air		Harfo			
	Funeral Director			Sex 7. A 1 ☐ M 2 ☑ F	Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,)		hirthplace (State or Foreign Country)		
			213-30-2427 Usual Residence of Decedent		72			Sept. 30	1932	Maryland		
	yland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	B Ma	ctor	Maryland Harfo	rd	Bel Ai	r				1 ☐ Yes 2 No		
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?		
	ba filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23e or 28e-f ehow event, the Medical Examiner must be incitified at	rai	813 Marcie Cour				21014		USA			
	ter de Items	Funeral Director	11. Marital Status	12. Was Deceden	it Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lisp <i>a</i> nic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.		
36	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖫 Divorced	1 ☐ Yes 2 % If Yes, Give Year or Dates		1 ☐ Yes 🏖 No	Specify:		Specify:	Tiffe i + a		
Š	2 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation	. 16	6b. Kind of Busines	White s/Industry		
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21	filed withi Hygiene. other than ant, the M	Con		4	Admini	strative	Assistar	nt F	arochial	Education		
nd	tal H d oth	Be	17. Father's Name (First, Middle, La					me (First, Middle, Ma	iden Sumame)			
yla	should ba ind Mental s markad o umatic eve	은	Norman Joseph						Walsh			
Maryland 21215-0036	2 2 3 2		Norman Van Ren					ural Route Number, (, Zip Code)		
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non	0 0		1 ABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	e cemetery, crei	natory or other plac			200000000000000000000000000000000000000			
			21. Signature of Funeral Service Lice		St. Georg	e's Episc 2 Name and Addre	popal 11-	-8-04 P Home, P.A.	erryman,	Maryland		
B	permit. Departr Imports any inji		WILL Was	not tou	1 7	McComas E 1317 Coke	uneral F	Home, P.A.	don MD '	21.000		
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	/Medical		resulting in death)	a	s a consequence of);					17170070103		
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68	requires that the death certificate een signed by the attending phys nould be detached for use as the			d					111			
Вох	leath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Te			23d. Date of d	elivery		
ω.	deatl	sicia	in the past 12 months?			Ectopic pregnancy Other (specify)			Month	Day Year		
P.O.	at the de by the stached	hys	9 ☐ Unknown									
Ś.	ires tha signed d be del	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause give	en in Part I,			to the cause of death?		
orc	w requir been si should	eted	117 7 600	CIVIOUNIA				1 ∐ Yes	2 No 3 F	Probably 4 MUnknown		
Records,	2 2 2	ompleted						24a. Was an autopsy	prior to	autopsy findings available completion of cause of		
		O						performe 1 ☐ Yes 2		s 2□No		
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		t 3 DOA Oth	20	ath (Check only one)		-		
		: To	1 ☐ Yes 2 ☑ No 27. Man or of Death	1 Inpat		1 JU DOA	4 🗀 Nuising F	lome 5 X Residence 28d. Describe how		ecify)		
O	Attending Phy r death. ector: After thi by the funeral or	tion	1 A latural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, D	ay Year) Injury	Worl	k? Yes 2 □ No	200. 20001130 11011	injury occurred			
Division of	Attendi r death. ector: A by the fu	ifica	3 Suicide 6 Could not	A 286. Place of it	njury - At home, farm, str	eet, factory, office				Rural Route Number,		
Ö	talor s afte al Dir	Certification:	4 Hottlicide	building, e	ic. (Specify)			City or Town, S	otate)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex.	Physicien: To the bes aminer: On the basis and manner s	t of my knowledge, death of examination and/or inv tated.	occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner a and place, and du	as stated. se to the cause(s)		
	To the within 2. To the I complet	M	29b. Signature and Atle of certifier	101	Ω-	29c. License		29d	Date signed (Mor	nth, Day, Year)		
)	7		> DYY	Johnes	u , 50	HY	0769		11/3/04			
	10		30. Name and address of person wh				ry M. Do	hmeier, po	nmr	21015		
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	Sta Registr		31. Date filed (Month, NOV 0 5	2004 D	trar's Signature	4 Low	de 1					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 0 0 4 35161 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month T **Physician** MONEUK 1025 AM 30 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA 1ERCY BALTIMORE HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 215.04.3932 MD **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Items 23a or 28a-f shov ner must be notified at BALTIMORE MD Be Completed by Funeral Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21216 4242 BONNER ROAD U.S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc traumatic event, the Medical Exandrer 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK ŏ 1 ☐ Yes 2 ☑No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 10th grade

17. Father's Name (First, Middle, Last) NIA HOMEMAKER DOMESTIC Pages 1 and 2 should be filed vent of Health and Mental Hygie int; If item 27 is marked other to 18. Mother's Name (First, Middle, Maiden Sumame) DORIS E. JOHNSON EDWARD WATTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1045 BRISTOL PLACE BALTIMORE, MD 21225 of Health ROSENA GEORGE/AUNT other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 perrit. Page Department o Important: If any injury or 11.05.04 BALTIMORE, ND MT. ZION * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
VAUGHN GOREENE FUNERAL SERVICES
5151 BALTIMORE NATE PIKE BALTO. MD 21229 ang 23a. Part 1. Extact he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** TNEVNONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by ombo cy to Denia 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 NO of Vital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST PAUL DOSEPH PLACE BACTCHORE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2004 Registrar

		-	For State Registrar	State of Mai	ryland / De	partment of Hea ertificate of De	aith and Me eath		en2004	35162
	Physicia	an	1. Decedent's Name (First, Middle, Last,	Pearlena	Lewis	Woolridge		2. Date of Death Month	Day Year	3. Time of Death 6:45 p M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Lo		10	28 2004 4c. County of Death	
H	Zxami	•	5288 Corncockle	Ct		Columbia			Howard	
	Funeral Director		5. Social Security Number 6. Security Number 336-16-4973 Usual Residence of Decedent	7. Age	(In yrs. last birtho 89 Yrs	Months Days I	Hours Min.	8. Date of Birth (Month, Day, 4-4-19	Year) 9. Birth Cou	nplace (State or Foreign untry) Ga
	yland 10W		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	se Mar	Director	Md Howard	l	Columb					1 ☐ Yes 2 TNo
	with th	Dire	10e. Street and Number 5288 Corncockle	C+		10f. Zip Code		10	g. Citizen of What Cou	untry?
	death ms 23	Funerai		12. Was Decedent Ev	ver in U.S.	21045 3. Was Decedent of Hispa If Yes, specify Cuban, I		ify Yes or No-	USA 14. Race - Amer	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Exptr. The motified at ODGe.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			мехісап, Риепо н Specify:	ican, etc.)	Specify: B	, etc. 1ack
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72	l withir iene. r than	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) "	Minister			Church	
g	al Hyg	Be C	17. Father's Name (First, Middle, Last)			18	3. Mother's Name	(First, Middle, M	aiden Sumame)	
<u>Y</u> a	ould b	2	David Lewis	0.1.0	**		Mary Jo		0	
Mar	id 2 sh lth and 27 is m traum		19a. Informant's Name/Relationship (T) Pearlena Patters		E.J.	ailing Address (Street and 88 Corncock1				p Code)
Je,	of Heal		20a. Method of Disposition		20b. Place of D	sposition (Name of crematory or other place)	Da		Oc. Location - City or 1	Town, State
Ë	Page ment c ent: if		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		Metro	Crematory			Catonsville	e, Md
Balt	permit. Depart import any inj		21. Signatur o Funeral Service Licens	Kug	Ut	22. Name and Address of 4300 Wa			West 1to, Md 21	215
			23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the cause of the			such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Prrysician /Medical	i	Infrediate Cause (Final disease or condition resulting in death)	a	consequence of)	oke				
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			IF FEMALE:							
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<u>α</u>	res that the de igned by the a be detached t	y Ph)	Part II. Other significant conditions co	ntributing to death but	not resulting in th	e underlying cause given i	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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Records,	e law has b	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	6. Place of Death	1772		
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Division	o Hospitel or Attendi 124 hours after death te Funeral Director: A letely filled in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.		, street, factory, office	28	Bf. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Haspitei or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/o	eath occurred at the time, ir investigation, in my opini	ion, death occurred	d at the time, dat	te and place, and due	to the cause(s)
,	To the within 2 To the complet	Σ	29b. Signature and title of certifier	_ M		pe, Print) Aparly	umber () 870	29 /\	d. Date signed (Month)	. Day, Year) Und 2004
Y)		30. Name and address of person who a SU2AN Abd	0, 500	ath (Item 23a) (Ty	pe, Print) 1 nal Bel	l Ln. C	Claritis	ulle MI	21029
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 5 2004	82. Registrar	's Signatur	Sparker				

UNK 04-357 04 - 7055

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Saryland Abersaninent of Health and Mental Hygiens

For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month NOVEMBER 1,2004 11:13p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3630 OLD FREDERICK ROAD BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. jast birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 216-90-1 M 2□ F Director Usual Residence of Decedent death with the Maryland 10a State City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or flems 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at Anne Arundel 1 Yes 2 No Director mo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Ave orman 2106 Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or flem any Injury or other traumatic event, the Madical Exempted 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ath IMOROVER Improvement Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Weaver 19b. Mailing Address (Street and Number or Rural Route Number City or Burn Street Zip Ma) Informant's Name/Relationship (Type, Print) Vorman 21061 Ave. Ballo. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Premation 3 Removal from State atonsville, mo Metro 4 Donation Other (Specify) Crematory uneral Service License 21. Signature Batto, ind 21229 tuneral Home r the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Pause (Final disease or condition resulting in death) Physician tiple Shotal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2ДTNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence State (Specify) SCENE Certification: To 1XXes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending Subject shot 23:14 investigation М 1 Yes 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At hon building, etc. (Specify) At home, farm, street, factory, office 4 X Homicide ellerisk Kozd Porc 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME NOVEMBER 2, 2004 M

State

Registrar

2004 DHMH 17 Rev 1/2001

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

101 32. Registrar's Signature

410Nic

ORIGINAL

Maryland 21201

				State of Maryland / Department of Health and Mental Hygiene 1 per Dr., G837, 11/95/0/dbb of Death 35/64
		° Physici		1. Decedent's Name (First, Middle, Last) David Bernard Wilkens Sr. 2. Date of Death Month Day Year Year
		/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		Funeral		Baltimore VA Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
		Director		219 16 96 97 100M 20F 80 Yrs. Months Days Hours Min. (Month, Day, Year) Country)
		laryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
S		the Ma	Director	MD. Ya DAHMONE 100 Zin Code 100 Citizen of What Country?
ίΛ		23a or	al Dir	106. Street and Number 106. Zip Code 10g. Citizen of What Country? 1400 I Mudson Statist Apt 202 2/205 11.5.A
5		s after death with the Maryla , or items 23a or 28e-f shor a rifer must be redified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
77	0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show to Medleal Exercitar must be footlind at	by	1 Never Married 2 Married 1 Nes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Specify:
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21	and	ed la pe	o Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
2	ary	d 2 should be th and Menta 7 Is marked treumatic ev	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20	Ε,	s 1 and 2 f Health item 27 I		VIOI WILLIAMS AUO Place of Disposition (Name of Date 200 Location - City or Town State
エアン	Baltimore			1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
2	3alti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 13 € HS Funeral Home
Davi	m	20E # 3		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
		Friysician		Interval Between Onset and Death Onset and Death
		/Medical Examiner		Due to (or as a consequence of):
1		15 25	Je.	Sequentially list conditions, b. Concessive Heart Fairure Due to (or as a consequence of):
		be executed sician and burial-transit	Examiner	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
	68760,			Due to (or as a consequence of):
	89		Medical	IF FEMALE:
/#	P.O. Box	or Attending Physician: The law requires that the death certificated death. Difactor: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 \ Yes 2 \ No 9 \ Unknown \ Unknown \ Unknown \ 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Month Day Year
Jem#	s, P.	res that the digned by the be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
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	of \	Physic r this c	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of Injury. 28b. Time of 28c. Injury at 28d. Describe how injury occurred
	ion	tending Ph feath. tor: After th the funeral	ation	1 □Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No
	Division of Vital Records,	or Atter after de Diracto in by ti	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
		To the Hospitel or Attendin within 24 hours after death. To the Funeral Diractor: Aft completely filled in by the fur	edical Co	29a. Certifier (Check only and declared at the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
_		To the within 2 To the complet	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
				P15389 10/29/04
/	j	4		30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)
1		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Squature
		Registr	ar	NOV 0 5 2004 Server & sporter

State of Maryland / Department of Health and Mental Hygieze 0 0 4 35165 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Samuel Weitzel, Sr. October 30, 2004 1152 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Mar. | 2, 1933 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) TXCXM 2□ F 71 220-30-4225 Director Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumetic event, the Medical Examiner must be notified at Maryland N/A XXYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3422 Hickory Avenue 21211 USA or Items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XDNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentat Hygiene. Importent: If Item 27 is marked other then "netural", or Iten any njury or other treumetic event, the Modical Examinat 1 Never Married XX Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Weitzel Rose Marsh ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Weitzel Wife 3422 Hickory Avenue Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial 11/03/04 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dorsey, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Lices 21211 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEURDI worth disease or condition resulting in death) /Medical **Examiner** CUMONARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit DIAGETES Due to (or as a consequence of) Box 68760 physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 No 3 ☐ Probably 4 ☐ Urrknown 1 Tyes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Tyes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending Injury death. 2 Accident 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10661 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21218 - MERAE STARKT State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:30 AM WATSON VOYEMBER 1,2004 MARIE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death AUT, MORE MEDICAL Date of Birth (Month, Day) 9. Birthplace (State or Foreign If Under 24 Hrs 5. Social Security Number Months 1 □ M 2 F 19.32.8072 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City /Town or Location 1 Yes 2 □ No DAUTI MORE MD Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? Street and Number (). S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Caban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use rating) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry HEACTHCARE Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAMMONDS Ct. DAVEHTER 600 INGELA 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 11.8.04 OWINGSMILLS, MARYLAND 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility VAVAIN C. CIREENE FUNERIN HM 21. Signature of Funeral Service Licensee BATIMORE, NO 21212 ausi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Atheroscleratic Valcular LOYRS disease or condition resulting in death) Due to (or as a consequence of): Reno vas cul AR Hypertens won Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): DiAbetes that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O Besit 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ➤ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

/Medical Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, page 2 should be

death.

24 hours after deal e Funeral Director:

within 2

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filled in

Medical

Physician

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Examiner

Funeral

Director

or 28a-f show

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Pages 1 and 2 should nent of Health and Mer

item 27

Department of I smportant: If its any injury or o o occes.

Pnysician

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Be Completed director, Certification: To funeral

5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

and manner stated. 29b. Signature and title of certifier

29c. License number D 00577 40 29d. Date signed (Month, Day, Year) NEV, 4, 2004

21286

KAluiH

Wiley MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8501 Las Alle

32. Regist ar's Signature

Ste 102 , TOWSOH , MD

State Registrar

		1	For Amend Item 19	State of Maryland / pb per fh 6837 1	Department of Health ar I-5-04 tas Certificate of Death	nd Mental Hygien Reg. พ่	2004 35167
	Dhysisis		1. Decedent's Name (First, Middle, Last,			2. Date of Death	3. Time of Death ay Year 214, 2204 8:15 P.M
	Physicia /Medic	al	Carol N.	Wheelek.	4b. City, Town, or Location of I		c. County of Death
	Examin	er	ta. Facility Name (If not institution, give Saint Joseph I	Medical Cente		WSOR	Baltimore
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last t	oirthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country) Mary (and)
	pug 🔺	- ⊢	Usual Residence of Decedent 10a, State 10b, County	10c. City, To	wn or Location		10d. Inside City Limits
	Maryla -1 sho	tor	MA BALTI	MORE	BALTIMORE	-	1 ☐ Yes 2 No.
	th the	Funeral Director	10e. Street and Number	1	10f. Zip Code	10g. C	Citizen of What Country?
	s 23a	Frail	6 Cavalcade Ct.	12. Was Decedent Ever in U.S.	13 Was Decedent of Hispanic Origin	n? (Specify Yes or No-	14. Race - American Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show it items 27 is marked other than "natural", or items 27e or 28e-f show or other traumatic evant, Ite Madical Exacting must be notified at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, f	Puèrto Rican, etc.)	Black, White, etc. Specify: White.
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.e, 1	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any Injury or other tra once.		20a. Method of Disposition	20b. Place	of Disposition (Name of	Date 20c.	Location - City or Town, State
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Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Livens	the state of the s	00 None and Address of Facility	ORE, MD 21	234.
	205 2 3		230 Bart Enter the disease or comp	lications that baused the death. D	to not enter the mode of dving, such as ca		CHARFORD RD. Approximate
			Immediate Cause (Final	/	o not enter the mode of dying, such as ca	, , , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death DAYS
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9 x	leath certific attending p I for use as	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
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o		n: To	1 ☐ Yes 2 X No 27. Manner of Death	1	b. Time of 28c. Injury at Injury Work?	28d. Describe how in	
ion	Attanding R death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investigation		M 1 Yes 2 N		111
Division	i or Attand after death Diractor: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Medical Co	29a. Certifier (Check only one) (Check only one)	ysician: To the best of my knowler niner: On the basis of examination and manner stated.	dge, death occurred at the time, date and and/or investigation, in my opinion, death	place, and due to the cause occurred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of cartifier	m-elte m	29c. License number		Date signed (Month, Day, Year)
)) chilling		1) 41410	210	remain ey ; 2004.
	1.		30. Name and address of person who			SON. MARYLA	ND 21204
	St	ate	JOSINDER MEHTO 31. Date filed (Month, Day, Year) NOV 0 5 2004	2. Registrar's Signature		SON, MAKYLE	71 V hat have do have the map
	Regist		INU V U D ZUU4	Jan 1	posts		

State of Maryland / Department of Health and Mental Hygiene 2004 35168 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:00 P M OCTOBER 2004 30 VIOLA WORTHMAN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner HARFORD MARINER HEALTH OF FOREST HILL FOREST HILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. 11/22/1917 Pennsylvania 86 Director 220-07-9509 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show or items 23s or 28s-f show acting must be notified at 1 ☐ Yes X☐ No Delta Director PA York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 17314 38 Bluebird Trail Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Maryland 21215-0036 Specify: White The Medical Exac-Completed by 3X Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) Furniture Store Owner marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) , and 2 should be fil.

If Health and Mental Hyc.

tem, 27 is mark-17. Father's Name (First, Middle, Last) Be Lula Grace Heare William Eston Dasher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2086 Hawksmoor Drive, Conway, S.C. James W. Compher Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 'Department of Himportant: If ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11/2/2004 Red Lion, PA Red Lion Cemetery 21. Signatur of Fyneral Service Litensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death remediate Cause (Final disease or condition resulting in death) **Physician** eime Year /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, pe 2 DNO 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 1 Yes 2 No this certificate Division of Vital Physician: 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical examiner' Other: Hospital: 1 🗌 Yes 2 210 1 Inpatient 2 ER/Outpatient 3 DOA 4 ursing Home 5 Residence 6 □Other (Specify) 27. Mayor of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death Director: / the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide P e Hospital 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hou To the Fune completely fi (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 8 LAW STREET ABERDEEN, MD MANUEL LAZATIN 21001 2. Registrar's Signature 31. Date filed (Month, Day, Year)
NOV 0 5 2004 State Registrar

			1 - For State Ragistrar	State of Maryland / De	epartment of Health and Certificate of Death	Mental Hygiene 001	35169
	Physici /Medio	al	Decedent's Name (First, Middle, Last	M. WIRTI	4b. City, Town, or Location of Dea	2. Date of Death Month Day Yea // th 4c. County of De	4 3.00 M
	Examin Funeral Director	er	5. Social Security Number 6. S	ire Center	PACKVILLE day) If Under 1 Year If Under 24 Hrs Months Days Hours Min	BALT S. 8. Date of Birth 9. 8	7 MORE Sirthplace (State or Foreign Country) LRM/ ANUN
	e Maryland te-f ahow tifled at	ctor	Usual Residence of Decedent 10a. State 10b. County BALT	MORE 10c. City, Town o	ar Location ARKVILLE		10d. Inside City Limits
	s 23a or 26	Funeral Director	10e. Street and Number 8832 Walther	Blud.	10f. Zip Code 21234	10g. Citizen of What (4
2-0036	o within 72 hours after death with the Maryland siene. Then "netural", or Items 23a or 28e-f ahow The Medical Examining must be notified al	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 Pyes 2 No Specify:	specify Yes or No- no Rican, etc.) 14. Hace - An Black, Wh	nerican Indian, nite, etc.
1-01212	T	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of wo fe. DO NOT use retired)	orking Refair	ss/Industry
ıryiand	2 should be filed and Mental Hygi is markad othar aumetic evant, I	To Be (17. Father's Name (First, Middle, Last) TAMES & U 19a. Informant's Name/Relationship (7)	voe Print) 196. N	Agn	me (First, Middle, Maiden Sumame) LS LUAL LOU ural Route Number, City or Town, State,	Zin Code)
e, Ž	ies 1 and 2 of Health a If itam 27 is or other tra		20a. Method of Disposition	20b. Place of D cometery,	isposition (Name of crematory or other place)	Plate 20c. Location - City of	21234 - or Town, State
	permit. Page Department o Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	1110101	Sary Lemerry 11-22. Name and Address of Ficility 2 EVAUS FUNGRACE	5-04 DALTI M ALTI MORE, MO HAPEL XXXX HARFO	MORE MI 21234.
ı	hysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Alzheime	e's Disease		Approximate Interval Between Onset and Death
(i no	be executed xx ician and purial-transit and and purial-transit and and and and and and and and and and	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d			
	certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of di Month	elivery Day Year
ecords, P.	The law requires that the death ate has been signed by the atter age 2 should be detached for the atternance.	þ	Part II. Dthar significant conditions on	ontributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐ F	to the cause of death?
	Ine lar ate has page 2	Completed		osis	disease	performed? death?	autopsy findings available completion of cause of s 2 \(\sum \) No
= :	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		ath (Check only one)	
io uoi	E E E	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		e of 28c. Injury at	dome 5 Residence 6 Other (Sp. 28d. Describe how injury occurred	ecify)
DIVISION	lo ha Hospital or Attanding within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)		28f. Location (Street and Number or F City or Town, State)	-1
	a Hosp 24 ho a Fune etely fi	edical	29a. Certifier 1 Certifying Phy (Check only 2 Madical Exemone)	ysicien: To the best of my knowledge, di iner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	 and due to the cause(s) and manner a urred at the time, date and place, and du 	as stated. se to the cause(s)
	within To th comp	Me	29b. Signature and title of certifier		29c. License number	29d. Date signed (Mon	nth, Day, Year)
			a an	ronico	1758646	November	3, 2004
	10		Anna Monias	sompleted cause of death (Item 23a) (Ty	pe, Print)	Parkville, Mr	21234
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	ion water ,	

DHMH 17 Rev 1/2001

Worth, agree 1/02/04 3 pm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death Month

					,	Certificate of	Death		Reg. No.	104	35170
	D		1. Decedent's Name (First, Middle			2		2. Dete of De Month	eath Day	Year	3. Time of Death
-	Physicia /Medic		PAUL	ZE	LLEY			10	29 2	2004	6.50Pm
	Examin		4a Fecility Name (If not institution	n, give street end number)			4b. City, Town, or I	ocation of Deeti	h 4c. County	of Death	
<u></u>				Rossville		Williams 1 Voor	Rossville	10 D . (D)	Balti		
	Funeral		5. Social Security Number	1□M 2□F	e (In yrs. lest b	irthday) If Under 1 Year Months Days		8. Date of Bir (Month, Da	ay, Year)	9. Birthpli	lace (State or Foreign try)
	Director	-	213 07 2655 Usuel Residence of Decedent	x 87		110.		Septemo	er 22 191	/ Balti	imore,Maryland
	Pue *	ŀ	10a. Stete 10b. County		10c. City, To	wn or Location				10	0d. Inside City Limits
	f she	5	Maryland Baltim	mao.	Raltim	ore County					1 ☐ Yes 2 ☐ No X
	the 1	Director	10e. Street and Number	T.C.	Darthir	10f. Zip Code			10g. Citizen of	What Count	
	with with		4906 Linda Avenue			21236			USA		
	72 hours efter death with the Marylend natural; or flems 23s or 25s-f show deal Examiner must be notified at	Funerai	11. Marital Status	12. Wes Decedent I	Ever in U,S.	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S	pecify Yes or No		ce - America	
_	r iter	교	1 ☐ Never Married 2 ☐ Marri	Armed Forces? ied 1 ☐ Yes 2 ☐ X	No	1		o Hican, etc.)		ck, White, e	
07	urs e	Ď	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify	whit	te
21215-0020	n 72 hours *natural', edical Exa	Completed	15. Deceden	t's Educetion st grede completed)	16	a. Decedent's Usual Occu	pation	kina	16b. Kind of B	usiness/Ind	lustry
7	C . S	p e	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use retire	ed)	3			
7		5	10	N/A	P.	lumbing Contrac	tor		Paul F Z		Inc.
pu	be filled ttel Hygid d other event,	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Nar	ne (First, Middle	, Maiden Surnan	10)	
Maryland	should be and Mentel marked o	ဂ္	Andrew F Zeller				Mary Anna	Hefner			
ar	she send seum		19a. Informant's Name/Relations	hip (Type, Print)	19	b. Mailing Addrass (Stree					Code)
			Charles F Zeller		1001 01	4906 Linda Av	enue Balt	and the same of	yland 212		01-1-
ore	5 5 2		20a. Method of Disposition 1	3 □Removal from State	cemet	of Disposition (Name of ery, crematory or other pla		Date	20c. Location		
Ē	nit. Peges. ertment of l ortant: if ite Injury or of		4 Donation 5 Other (S		St Jos	seph Church Cerr			Baltimon	e,Maryl	land
Baltimore,	permit. Pege Depertment of important: if any Injury or pnce.		21. Signature of Funeral Service	Licensee	4	22. Name and Addr Lassahn Fun	ess of Facility eral. Home I	nc			
ш	2023	-1	Matterda	och Omr	rocki	7401 Belair	Road Balti	more, Mary	land 2123	6	
+			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. Do	not enter the mode of dy	ing, such es cardia	or respiratory a	irrest,		Approximate Interval Between
\$	Physician								-	÷	Onset and Death
تمس	/Medical		Immediate Cause (Final disease or condition	Pro	bolos	a consequence of):	Cen	Cer			
	Examiner		resulting in death)	d	Due to (or as a	a consequence of):		0 0			
	Si 20	Examiner		o Chm	nic	Obstruc	tire	Inhon	rong 6	hee	ne
P	The law requires that the death certificate be executed ate has been signed by the ettending physicien endinges 2 should be deteched for use as the bunel-transit	Хат	Sequentially list conditions,			consequence of):	1	6	1	i	
60	cien burie		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	C	Hiat		a chy ca	rang			
68760,	physi the	edical	that initiated events resulting in death) Last	15		consequence of):	int D			i I	
×	ding se es	2		d. Deg	enigi	true 10	mt D	Heare			
Box	v requires thet the death ce been signed by the ettendii should be deteched for use	Physician/						001 514		- 4 - 10 - 4 - 4 -	the second of death 2
o	he de the ched	ysi	Part II. Other eignificant condition		ut not resulting	in the underlying cause g	ven in Part I.		/		the cause of death?
P.0	thet t ed by dete	g.	kyph	cois				10	Yes 2□ No	3 I FIOD	ably 4 officion
ds	sign d be	d by	,	vois extensiis				24a. Wes	an autopsy		ere autopsy findings
ò	been	ete	Alls	stensin				perfe	ormed?	con	ailable prior to mpletion of cause death?
Rec	e law hes ge 2	Completed						10	Yes 28110		Yes 2□ No
a		8	OF Management to medical	1			26 Place of Do	ath (Check only			7165 2010
of Vital Records,	Physician: The law this certificete hes t ral director, page 2 s	Be C	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:		Outpatient 3 DOA	thor		idence 6 □Oth	ner (Specifi	w)
of	al call	5	27. Manner of Deeth	28e. Date of Inju		. Time of 28c. Injury We			how injury occur		7
o	After fune	Į.	1 Natural 5 ☐ Pendi	ng (Month, Da gation	y Year)		ork?]Yes 2□No				
3	Attending or deeth.	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Inj	ury - At home,	farm, street, factory, office	9	28f. Location (Street and Numi	ber or Rura	l Route Number,
Division	or efter Dire	Certification:	4 Homicide	building, et	c. (Specify)			City or 10	wn, State)		
_	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	aic	29a. Certifier	ng Physician: To the best	of my knowled	ge, death occurred at the	time, date and place	, and due to the	cause(s) and m	anner as st	ated.
	Hora Fur	edicai	(Check only 2 Medical one)	Examiner: On the basis of end manner sta		end/or investigation, in my	opinion, death occu	irred at the time,	date and place,	and due to	tne cause(s)
	Vithin To the	Me	29b. Signature and title of certific	er C			nse number		29d. Date signe	d (Month, I	Day, Year)
		1	> Bov	An	m	D D	31464		10/	291	04
	1		30. Name end eddress of person	who completed cause of c	leeth (Item 23a) (Type, Print)			- +	0 1	
	•		SHOALIB 6	1. HASHMI	- 0	(N. Enta	no St	Sonte	308, 1	Sall	tome MD 2/201
	Sta	ite	31. Dete filed (Month, Day, Yeer		ar's Signature	(N: Enta			,		2120
	Registi	8.0	NOV 0 5 1	2004 Dun	na /	5 sporks	1				

DHMH 16 Rev 6/95

			For State Registrer 1. Decedent's Name (First, Middle, Last,	State of Ma	ryland /				ealth a	and M	2. Date of De	Reg. No.	04	35171
	Physicia /Medic Examin	an al	VIRGINIA 4a. Facility Name (If not institution, give Atlantic General	ELIZABET street and number)	H AY		-	Town, or erlin	Location of	of Death	Month 10		y of Deeth	2:35m
*	Funeral Director		5 Social Security Number 6 Sec	7. Age	(In yrs. last i	birthday) Yrs.	If Under Months	1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bin Month, Da 5/30/1			lace (State or Foreign try) MD
	e Maryland	ctor	10a. State 10b. County	cester	10c. City, Town or Location Ocean City							10d, Inside City Limits XX es 2 □ No		
980	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "naturel", or Items 23s or 28s-f show event, I'rs Mudical Evaid, ar must be cofficed at	I by Funeral Director	14001 Lightho 14001 Lightho 11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	Duse Ave. 12. Was Decedent E Armed Forces? 1			Vas Dece Yes, spe	218 dent of Hi city Cubar		gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	Bia		an Indian, etc.
Maryland 21215-0036	e filed within 72 ha il Hygiene. other than "natu	e Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)			ife. D	kind of wo	erk done d se retired,	luring mos			Schoo Maiden Suma	l Sys	,
arylan	2 should be and Mental is marked o eumatic eve	To B	Louis H. Strat 19a. Informant's Name/Relationship (7)		1		•		nd Numbe	r or Rura		er, City or Town		
	of Health of Health if Item 27 or other tr		George Ay 20a. Method of Disposition 1 Burial 2 & Cremation 3 □	Removal from State		of Dispos	sition (Na.	me of other place	9)	10/2	-	20c. Location	- City or To	wn, State
Baltimore,	permit. Pag Department Important: I eny injury c		4 □ Donation 5 □ Other (Specify) 21. Signal A of Funeral Service Lines		Cape	22.	Name a	nd Addres	s of Facilit	The	Burba lin, MI	Frank ige Fun 2181	eral l	
760,	Physician and Medical Examiner partial itansi	cai Examiner	23a Jan. Enter the disease or compositions, or head failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feature to find expressions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a d. Due to (or a) d. Due to	consequence	ce of):	-	ae or ayını	g, such as	cardiac c	respiratory a	rrest,		Approximate Interval Between Onset and Death MONTO
.O. Box 68	it the death certificate by the attending physi- tached for use as the I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal dea	ath 3 🗆	Ectopic p	regnancy pecify)					ate of delive	ory Day Year
Records, P.	aw requires thats been signed a should be de	Completed by Ph	Part II. Other significant conditions co	ntributing to death bu	t not resultin	g in the un	nderlying (cause give	on in Part I		1 🗆	Yes 2 No	3 Prob	ably 4 Unknown psy findings available mpletion of cause of
Vital R	Physiclan: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe	25.		1 ☐ Yes	one)		2 No
of	Jing After fune	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 281	Outpation b. Time of Injury		28c. Injury Work	4 🗆 140			dence 6 ⊡Ot how injury occu		7
Division	oital or Attendurs after deathurs after deathural Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.	(Specify)					The second second	City or To	wn, State)		l Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medicai	(Check only 2 Madical Exam	rsician: To the best of iner: On the basis of and manner state	examination		estigation		oinion, dea				, and due to	the cause(s)
	wit.		29b. Signature and title of certifier	IL	ph	4510	10-	1	44	185	3	10/2	4/00	4
٤	72		30. Name and address of person who of Robert Dur	(K-2) 9	733	Her	Thw	in the	Driv	والم	Berl	en, in	10	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	nn/ 32. Hoistra	r's Signatur	e L	1. 1/2		20					

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Virginia Ay 220-18-4739

			1 - State Amend Item 8 Registrar	State of M per fh G	larylan 837 1	d / Depa 1−15 <u>−</u> 0	rtmen tificat	t of H e of L	ealth a Death				004	35172
ı	Physici		1. Decedent's Name (First, Middle, Las Charlotte Jac	quelin	And	erson					2. Date of Deat OCT.19		0 4 Year	3. Time of Death 9:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give 8799 King George 5. Social Security Number 579-42-7837	ge Ct.	·	last birthday)		fre	Location of		8. Date of Birth	(charle	S place (State or Foreign
	Director works	_	Usual Residence of Decedent 10a. State 10b. County	□ M %(% F	10c. City	Yrs.				•	NOV: 1	1 -1 >	35- Wa	10d. Inside City Limits
	th the Ma or 28a-f	Directo	MD Charle 10e. Street and Number	S	Poi	mfret	10f. Zip	Code			1	0g. Citize	n of What Cou	1 ☐ Yes 2 🙀 No ntry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other treumatic event, the Modical Examinat must be putilised at	Completed by Funeral Director	8799 King Georg 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	e Ct. 12. Was Deceden Armed Forces 1 Yes 27 If Yes, Give Year or Dates:	i?] No		Was Decer f Yes, spec 1 Yes	dent of Hi cify Cuba)675 spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)	14.	ISA Race - Ameri Black, White Decity: Wh	etc.
121215-0036	12 should be filed within 72 ho h and Mental Hygiene. 7 is marked other than "natur treumatic event, the Mcdical		15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12) 12		r 5+)	life. I		rk done o se retired	luring mos)	of workin	g		of Business/Ir	•
Maryland	buld be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, Last) Charles J. Elli						Mar	у М.	(First, Middle, Models)			
	s 1 and 2 sho f Health and flem 27 is m other treum		Joseph P. Ander 20a. Method of Disposition	son,Jr.	20b. P		8799 sition <i>(Nai</i>	Kir me of	ng G	eorg		Pomf		D 20675
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other treu		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature) of Funeral Service Licen)	Bri	nsfie A	ld-E REHA	cho] R#∞]	Ls C: SOHO	LS F	10/2 <u>1</u> UNERAL 1ata,M	HOM	ſΕ, PA	otte Hall MD
8760,	Physician per executed attending physician and attending physician and for use as the burial-transil	dicai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of the state of the sta	a. Due to (or a b. Due to (or a d. Due to (or	line. s a consequence a conseq	uence of):	er the moo	de of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
.O. Box 68	the thed	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3□	Ectopic p					230	d. Date of deliv	ery Day Year
Δ.	w requires that it been signed by should be detac	þ	Part II. Other significant conditions of	ontributing to death	but not resi	ulting in the u	nderlying o	cause give	in in Part I		23e. Did tob	-/	,	he cause of death?
Il Records,	The law ate has b page 2 sl	Completed									24a. Was all autops perform	y	24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes	Hospital: 1 ☐ Inpat	tient 2 🗆	ER/Outpatier	it 3□ D0	Othe	26.		(Check only online 52 Reside		Other (Speci	fv)
ion of	Attending Physic death. sctor: After this by the funeral di		27. Manner of Death 15 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury	28b. Time of Injury		28c. Injury Work	at	2	8d. Describe ho			,,,
Division	i gitt	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of I	njury - At ho etc. <i>(Specif</i>)	ome, farm, str y)	eet, factor	y, office		2	8f. Location (St. City or Town	reet and N n, State)	lumber or Run	al Route Number,
	he Hospitel in 24 hours a he Funerel I pletely filled	edical	29a. Certifier (Check only one) Check only one Certifying Ph	ysician: To the bes niner: On the basis and manners	of examina	wledge, death tion and/or in	occurred vestigation	at the tim n, in my op	e, date an pinion, dea	nd place, a ath occurre	nd due to the ca	ause(s) an ate and pla	d manner as s ace, and due t	stated. o the cause(s)
	To the within 2 To the Comple	Σ	29b. Signature and title of certifier	An)	ar	N	29	c. License	number 2) (2	29.	9d. Date s	20 /	Day, Year)
	DB b		GERNA	LHU	death (Item	STER	7	M, Y	? 1	W P	1600	rux-	M	20603
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	2004 32. F gis	strar's Signa	turdy A	S. S.							

			1 - For State of Maryland / Dep Registrar Ce	artment of Health and Martificate of Death	Mental Hygien	2004 351/3
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Patricia Ann Adkins 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	OCTOBER :	3. Time of Death 20, 2004 9:30P C. County of Death
	Funeral		CIVISTA MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	LAPLATA If Under 1 Year If Under 24 Hrs. Months Days Hours Clip.	8. Date of Birth	CHARLES 9. Birthplace (State or Foreign 2,1938 outwashingto
	Director Mous	L	10c. City, Town or L	ocation	ptember z	2,1930 Washingto
	with the Ma a or 28a-f	Director	MD Charles Waldor 10e. Street and Number	10f. Zip Code	10g. C	1 ☐ Yes 2 📉 No itizen of What Country?
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or Items 23a or 28a-1 show event, tra Medical Era ninst transite rodified at	by Funeral	1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No	Uses 2 No Specify:	pecify Yes or No- p Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	filed within 72 ho Hygiene. other then "natur ant, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 (Give life. H	edent's Usual Occupation Is kind of work done during most of work DO NOT use retired) OMEMAKET	king	Kind of Business/Industry Home
ıryland	e d d	To Be	17. Father's Name (First, Middle, Last) Pedro Baquial 19a. Informant's Name/Relationship (Type, Print) 19b. Maili		e (First, Middle, Maide) oeth Mary	Baquial
	1 and 2 Health a sm 27 ls		Donald Adkins/Husband 210 20a. Method of Disposition 20b. Place of Disposition	6 Dennis Road, V	Valdorf,M	
Baltimore,	permit. Pagas Department of H Importent: If ite any injury or of		4 □ Donation 5 □ Other (Specify) Resurre 21. Signature of Funeral Service Licensee	ction Cemeteryl 2. Name and Address of Facility AREHART-ECHOLS	FUNERAL	Clinton, Maryland HOME, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR Due to (or as a consequence of): Sequentially list conditions	R FIBRILLAT	or respiratory arrest, TON Distin	Interval Between Onset and Death
8760,	death certificate be exacuted e attending physician and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
O. Box 6	the death certificate be ex y the attending physician ched for use as the buria	hysician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P.	w requires that the dibeen signed by the should ba detached	by P	Part II, Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 26		use contribute to the cause of death?
	The lay ate has page 2	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
	shys this al dii	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ot 3 DOA Other: 4 Nursing Hor	n (Check only one) me 5 ☐ Residence 28d. Describe how injur	
DIVISION	To the Hospitel or Attending F within 24 hours after death. To tha Funerel Director: After completely filled in by the funer.	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)		City or Town, State	
	the Hospitel or hin 24 hours afte tha Funerel Dir mpletely filled in I	Medical	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date and	d place, and due to the cause(s)
4	viti To		29b. Signature and Me of certifier	29c. License number D-44436		te signed (Month, Day, Year)
1	B k		30. Name and a dress of person who completed cause of death (Item 23a) (Type, ASHVIN J. PATEL, MD 102 PAUL MF: 31. Date filed (Month, Day, Year) 32. Ru strar's Signature	ILON CT.SHITE10	2 WALDORF	7,MD20602
	Registra	-	OCT 2 2 2004	Conte		and the second s

PATRICIA

			1 = For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of F tificate of	Death	F	leg. No.	35174
	Physici /Medic		1. Decedent's Name (First, Middle, Last) DONALD LESTER	ARMENTROU	T, SR	•		2. Date of Dea	r 24, 20	3. Time of Death 1745 M
	Examin Funeral Director	_	4a. Facility Name (If not institution, give s CACTED THOM 5. Social Security Number 6. Sex 220-40-2257 Usual Residence of Decedent 10a. State 10b. County	## ## ## ## ## ## ## ## ## ## ## ## ##	ast birthday) Yrs.	If Under 1 Year Months Days	or Location of Dea	NA 8. Date of Birth	4c. County of the HILLY (1942), 1942 WE	Country)
в Магу	a-f sho	ctor	WV MINERAL	RI	DGELEY					1 ☐ Yes 2 No
death with the Maryland	3a or 28	I Director	10e. Street and Number ROUTE 1, BOX 559A			10f. Zip Code 26753	3		U.S.A.	Country?
ē		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.s Armed Forces? 1 _Yes	1	/as Decedent of No	is Decedent of Hispanic Origin? (Specify Yes or Nes, specify Cuban, Mexican, Puerto Rican, etc.) Yes X No Specify:			
-C121 within 72	jiene. r than "natul II.e Medicul	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	life DO NOT use retired)				16b. Kind of Business/Industry MACK TRUCK	
	e d fa	Be	17. Father's Name (First, Middle, Last)	m				me (First, Middle,	Maiden Surname)	
<u> </u>	a mark umatic	2	FLOYD E. ARMENTROU 19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street	OCIE K		r, City or Town, State	. Zip Code)
e, Mai I and 2 st	of Health a item 27 Is other tra		ROBERT ARMENTROUT			TE 1, BC	X 559A,	RIDGELEY		
more,			20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ Re 4 □ Donation 5 □ Other (Épecify)	moval from State	ametery, crem	atory or other pla	CORY 10/2		20c. Location - City of CUMBERLA	
Demit.	Department of Important: If any injury or once.		21. Signatureral Funeral Service Luns	1	22.	ÚPCHUŔCE	r funeral	HOME, P		21502
1	nysician Medical xaminer the prital-transit	Icai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) S nuential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	pence of):	The mode of dyll	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
THE COLUS, T.O. BOX OF THE IAW REQUIRES THAT THE DEATH CERTIFIC	CB off	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 1	Ectopic pregnancy Other (specify)	y		23d. Date of d Month	elivery Day Year
uires that	n signed by	by	Part II. Other significant conditions con	ributing to death but not resu	Iting in the un	derlying cause giv	ren in Part I.			to the cause of death? Probably 4 Unknown
	ate has page 2	Completed						24a. Was a autops perform	y prior to	
99	uis certif directo	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No He	ospital: 1 npatient 2 1	ER/Outpatient	3 DOA Ott	or	ath (Check only on dome 5 \subsetence Reside	e) ence 6 □Other (Sp	ecify)
_ §	e g		27. Mapner of D ath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		,	ow injury occurred	
DIVISION OF	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	791 - 11	28f. Location (SI City or Town	reet and Number or I n, State)	Rural Route Number,
Hospi	24 hou	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the best of my knower: On the basis of examination and manner stated.	vledge, death ion and/or inve	occurred at the tirestigation, in my c	me, date and place prinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
To th	within To the compl	Me	29b. Signature and title of certifier	Ω		29c. Licens			9d. Date signed (Mor	
1	12	1	30. Name and address of terson who con	npleted cause of death (Item	22a) (Time P	DE	0478		10/25	12004
	5 KS		AFAG OHMAL	625 Kes	at AM	- Cun	perland	L md.	10/25	2
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure g	home that	,			

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 20, 2004 Barbara Gladys Buete 1:43 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5760 Highland Lane Sunderland Calvert. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 9, 1936 9. Birthplace (State or Foreign Country)
Wash., D.C. **Funeral** Days Hours 1 □ M 2 🛛 F Director 68 Yrs. 578-44-8357 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show wherewat be notified at 1 ☐ Yes 2 🔀 No Director Sunderland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20689 USA 5760 Highland Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō Il Hygiene. other than "natural", or rent, Itre Medical Exam 1 Yes 2 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill treent of Health and Mental Hitem 27 is marked ott Be Mary Elizabeth ၉ Wallace Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5760 Highland Lane, Sunderland, MD George E. Buete, spouse 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: if Ite
any injury or oti
once. 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 10-25-2004 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. 20736 Rausch Funeral Home, P.A., Owings, MD tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer OBSTRUCTIVE PLIMING DISEASE dyrs Pnysician disease or condition resulting in death) /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Box 68760 Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy DOTTO Sk performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident hours after deat unerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospitel within 24 hours 2 To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 TOWN Square Dr. Ste Z 31. Date filed (Month, Day, Year) 32. Registras Signature State 1 2004

Registrar

as is personi

		ľ	State of Maryland / Department of Health and M 1- State Recistrar Certificate of Death		jien 2004	35176
		100	Decedent's Name (First, Middle, Last)	2. Date of Dea	th	3. Time ol Death
	Physicia /Medic		Charles Brawner	Month Oct 20	Day Year 2004	0023 M
	Examin	-10	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	eth
	*.	7	1300 Southview Drive, Apt #310 Oxon Hill, Maryla		Prince Ge	
P-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	year) 9. Bi	thplace (State or Foreign ountry)
	Director		578–54–9726 X 63 Yrs. Usuel Residence of Decedent	Nov. 30), 1940 Wa	shington, DC
	and ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
:	Mary ish ied	tor	Maryland Prince Georges Oxon Hill			1 ☐ Yes 2 ☐ No
	n the	Directo	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
	23£ 0	al D	1300 Southview Drive, Apt #310 20745	U	nited Stat	es
	ams ams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe Armed Forces? 14. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
215-0036	within 72 hours after death with the Maryland jene. Then "natural", or items 23c or 28a-1 show the Medical Evarning must be notified at	by	1 Never Married 2 Married 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify: B1	,
ဂ်	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working)	na	16b. Kind of Business	/Industry
N	within ene. than "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	.9		
N	filed w Hygier other th		12 Security Officer	(F	Security	
ב	ed ital	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name			
2	2 should to and Ment is marked sumatic of	70		Washing		7- 0- 4-1
=	d 2 st d 2 st th and 7 is r traur	1	19a. Informant's Name/Relationship (Type, Print) Norman Brawner, Sr./Brother 19b. Mailing Address (Street and Number or Rura 2512 Afton Street, Temp			
	ges 1 and 2 should it of Health and Mer if itam 27 is marke or other traumatic	l Y		The second second	20c. Location - City of	
saltimore,	Pages nent of int: If it iry or o		1 ဩBurial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem 10/27	7/04	Suitland,	Marvland
			21. Signature Februal Service Licensee 22. Nathernet Facility Hom	_		iidi y idiid
ñ	permit. Departi Importi any inj		5538 Marlboro Pike,			20747
r		0	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or head failure. List only one cause on each line.	r respiratory arr	est,	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition a. Attended for the Cardon Mascert	and Hee	IT Direa	Oncot and Doath
	/Medical		resulting in death) Due to (or as a consequence of):			
I	Examiner		Sequentially list conditions b.			
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ificate be executed physician and as the burial-transit	хап	resulting in death) Last Due to (or as a consequence of):			
Ď.	be e) ician buria					
09/89	ficate phys s the	edical	d.			
×	certif nding Ise a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	livery
ROX	it the death certif by the attending tached for use a	Physician/M	in the past 12 months? 1 Vec 2 No. 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
Ö	t the c by the acher	hys	9 □ Unknown 9 □ Unknown			
7	The law requires that the the has been signed by thoage 2 should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
Vital Records,	w require been sig should b			1 🗆 Ye	es 2□No 3□P	robably 4 Hinknown
000	awre as be 2 sho	Completed		24a. Was a		utopsy findings available completion of cause of
Ĭ	The I	mo		perform	ned? death?	s 2 No
<u> </u>	sician: The law certificale has l irector, page 2 s	Bec	25. Was case referred to medical exampment?			
0	Physic this corral dire	10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon		ence 6 Other (Spe	ocify)
Ē	ding P h. After t funera	on:	1 ☑Natural 5 ☐ Pending (Month, Bay Year) Injury Work?	28d. Describe ho	ow injury occurred	
<u>s</u>	itand Jeath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury. At home larm street factor, office	ISI Location (St	reet and Number or R	usal Bauta Numbar
Division	l or Attana after deat Director: I in by the	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify)	City or Town		urai noute Number,
_	Hospital or Attanding Physician: 44 hours atter death. Funeral Director: After this certific tely filled in by the funeral director.		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a	and due to the ca	ause(s) and manner a	s stated.
	To the Hospital o within 24 hours aft To tha Funeral Di completely filled in	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, d	ate and place, and du	e to the cause(s)
	To the within 2 To tha complet	×	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mon.	
			Horador Sylveties, Do 14005592	7 0	206 ar 2	3, 2004
_	(12)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVADOR Sylvester, 2001 Hospital Drive, Completed Cause of Death (Item 23a) (Type, Print)	verly	many las	rd
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	. /		
	Registr	ar	OCT 2 5 2004 Clave & Spark			

State of Maryland / Department of Health and Mental Hyglen Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician JOHN BROWN T. . October 2004 18 7:59 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY CHEVERLY

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea

August 28 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 226-38-8080 1933 Virginia 71 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or Itams 23s or 28s-1 show other traumatic event, the Medical Exeminar must be notified at 1
▼ Yes 2 No Prince George's Landover Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20785 2203 Vermont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Central Sterlizer Private 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be Edna Myers Frank S. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2203 Vermont Avenue Landover, Maryland 20785 item 27 le Patricia Brown/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If ite 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If eny injury or 2002e. 10-25-2004 Landover, Maryland Harmony Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 74/4 Landover Road Landover, Maryland 20765 1. H. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Anoxia Encephalopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Larygeal Carcinoma burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, nding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter Year 10 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed be should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Anemia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy has 2.2 No certificate 1 ☐ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 은 this After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural
2 Accident Division Injury Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who complet 31 cause of death (Item 23a) (Type, Print) Figaro M.D. Michael 3001 Hospital Drive Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 3. Registrar's Signature State 2 2 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiena Certificate of Death

2. Date of Death

Year

Month

the To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: filled in by completely

10:05P M OCTOBER 14, 2004 **HUGH MANSFIELD BERRY** 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ROCKVILLE
If Under 1 Year If Under 24 Hrs. SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. Yrs. NORTH CAROLINA 1930 245 20 5457 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "naturel", or items 23e or 28a-f show the Medical Examinar must be notified at XXYes 2☐No MONTGOMERY GAITHERSBURG MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7834 MINERAL SPRINGS DRIVE 20877 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No BLACK à Specify: XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4YRS. NORTHWEST ORIENT AIRLINE EMPLOYEE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any njury or other traumatic event QDCS. Be VIOLA BULLOCK HUGH WILLIAM BERRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GAITHERSBURG, MD 20877 7834 MINERAL SPRINGS DR. HUGH E. BERRY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GETHSEMANE CEMETERY 10/23/2004 ROCKY MOUNT, NC 21. Signatore of Funeral Service Licensee MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUTTLAND ROAD SUITLAND, MD 20746 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 WEEKS ATRIAL FIBRILLATION /Medical Due to (or as a consequence of): Examiner 2 WEEKS SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed 2 WEEKS PNEUMONIA use as the burial-tran and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical SEPSIS 2 WEEKS IF FFMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes XX No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page this certificate 1 ☐ Yes XX No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner Hospital: XIX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred XXVatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sigrature and title of m, M.1) D0040201 OCTOBER 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 EXECUTIVE PARK CT. GERMANTOWN, MD 20879 FARZAD ASSAR, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 2 2 2004 Registrar

DHMH 17 Rev 1/2001

			1 - State of Maryla		artment of H			giene 004	35179
			Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Physici /Medic		SADIE RENSHAW	BAULC	H		OCTOB1	ER 21 200	04 11.55a ^M
į	Examin		4a. Facility Name (If not institution, give street and number)			Location of Deat	h	4c. County of De	
			Frederick Memorial Hosp 5. Social Security Number 6. Sex 7. Age (In yrs	ital s. /ast birthday)	Freder	ick If Under 24 Hrs	8. Date of Birt	Freder	
	Funeral Director		412-18-0296 1 M 2 T 84	Yrs.	Months Days	Hours Min.	Jan.	27°, 1920°	inthplace (State or Foreign Country)
	D		Usual Residence of Decedent						MISS
	show	J.	10a. State 10b. County 10c. C	City, Town or Lo	erick				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	the M	ect	10e. Street and Number	Treu	10f. Zip Code			10g. Citizen of What C	
	hours after death with the Maryland tural; or items 23a or 28e-f show al Exand ret must be codified at	Completed by Funeral Director	5589 Brittany Ct.			1702	The state of the s	USA	ountry?
	death ms 2:	nera	11. Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	- 14. Race - Am	
9	or the	/Fu	1 Never Married 2 Married 1 Yes, Give		irres, speciny Cuba 1 □ Yes 2 □ X No	in, mexican, Puer Specify:	o Hican, etc.)		
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	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
yla	should be ind Mental marked o	To	Paul Renshaw					Machalpe	
Maryland	0 0 0		Joan Spinner (Daughter)					ir, City or Town, State, \mathtt{ille} , MD	· ·
	1 and 2 Health tam 27 other tr				sition (Name of		Date	20c. Location - City o	
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Baltimore,	permit. Pages 1 an Depurtment of Heal Importent: If Itam 2 any injury or other once.		21. Signature of Funeral Service Libertsee				_	neral Ho	
m	20 E 2 8		mires Chy		31 E. ma	ain St.	, Midd]	letown, M	D 21769
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	/Medical Examiner		Due to for as a for le	quence of	Prellato				2 cm Ho
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a			OS Was seen estaured to modified					2 ☑No 1 ☐ Ye	s 2 No
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) of	문 두 등	n: T	27. Manger of Death 28a. Date of Injury	28b. Time of Injury	1000	at		ow injury occurred	ecny)
sior	andlin eath. or: Afi he fur	atlo	2 Accident investigation	inquiry		Yes 2 □ No			
Division of	or Att after de Diract	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At a building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Town	treet and Number or A n, State)	lural Route Number,
	spitel ours a leral [29a. Certifier 12 Certifying Physician: To the best of my kr	lowledge deat	occurred at the tim	a data and place	and due to the	augo(a) and manner a	a stated
	To the Hospitel or Attanding Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or in	vestigation, in my op	pinion, death occu	rred at the time, d	late and place, and du	e to the cause(s)
	To th withir To th	M	29b. Signature and title of certifier		29c. License	number	/ 2	29d. Date signed (Mon.	th, Day, Year) 200 4
•			► ACUK SW			4651	D	UL 1015	EK 22
	5		TO Name and addition of person who completed cause of death (Ite	m, 23a) (Type,	TANEY	AVE	FRED	MD 217	02
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 5 2004	nature	is do	arkas			

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Viola October 0 16, 2004 2:30 P. M Bradley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville 4c. County of Death
Montgomery **Examiner** Potomac Valley Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 X F 94 218-62-6744 Director Yrs. March 03, 1910 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumetic event, the Medical Examiner must be notified at Maryland Montgomery Gaithersburg Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24109 Doreen Drive 20882 **USA** Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 1 Yes 2 No þ White Specify 3 Widowed 4 □ Divorced naturel Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done di life. DO NOT use retired) during most of working Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Home 12 0 Pages 1 and 2 should be filed vent of Health and Mental Hygie out; If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Sarah Rosella Metz John Wesley Fazenbaker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph W. Bradley-son item 27 I 24109 Doreen Drive, Gaithersburg, Md. 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of Finportent: If ite eny injury or ot once. October 20. 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Westernport, Maryland Philos Cemetery 2004 ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, Md. 21539 7-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician CARDIOPULMONARY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DYSPHAULA Sequentially list conditions, Due to (or as a consequence of) Physiclan/Medical Examiner cause. Enter Underlying Cause (Disease or injury sician and burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed FAILURE TO THRIVE that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. DEMENTIA , DEPRESSION the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performed 2 No 1 Tyes 2 No director. 25. Was case referred to medical 26. Place of Death Check onl one) examiner' Other: Certification: To 1 ☐ Yes 2√No 1 Inpatient 2 ER/Outpatient 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DO061959 10/18/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAS Lamberton Drive Silver Spring maryland 20902 MD 1299 31. Date filed (Month, Day, Year) 32, Registrar's Signature State OCT 1 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend interm 20b per beattiment of Fieldth and Mental Hygien 2001.

35181

		1 - State Registrar			Cer	tificate of	Deat	h		Reg. N	10.	00101
T-O-	ğ.	1. Decedent's Name (First, Middle, Las	st) ·						2. Date of De			3. Time of Death
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/Medic		4a. Fecility Name (If not institution, give		DELT		4b. City, Town,	or Locatio	n of Death	ocpt.		4c. County of Deat	
Examir	er			ni+-:		Cheve		iii oi Deatii			$P \cdot G \cdot$	11
* 2		Prince Georges 5. Social Security Number 6. S		(In yrs. last		If Under 1 Year		ler 24 Hrs.	0. Data of Bir			
Funeral		1	_ M 2 _X F / . Age	68	Yrs.	Months Days			8. Date of Bir (Month, Da	у, Үөа	ar) 9. Birti	hplace (State or Foreign untry)
Director		213-36-4776 Usual Residence of Decedent		00					5/14/	19.	36 MD	
and		10a. State 10b. County		10c. City, T	own or Loc	ation						10d. Inside City Limits
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and 21215~0036 be filed within 72 hours after death with the Maryland nial Hygiene. ed other than "natural", or Itams 23a or 28a-1 show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number				10f. Zip Code					Citizen of What Co	untry?
ath v	<u>ca</u>	1207 Addison F	RD.			20743				Ţ	U.S.A.	
r de	Jue	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of Yes, specify Cut	Hispanic (Origin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, White	
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should be and Mental marked imatic ev	ToE	Frank Thomas ()ueen				M	ary V	Willia	ms		
laryland	_	19a. Informant's Name/Relationship (7	ype, Print)	1	9b. Mailing	Address (Stree	t and Nurr	ber or Rura	I Route Numb	er. City	or Town, State, Z	in Code)
re, Maryle s tand 2 should f Health and Mer item 27 is mark other traumatic		Lynette Giles/	aughter		1807	Belle	Hav	en Di	r.#302	Lai	ndover,	MD
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of		0.01	ate .	20c. l	Location - City or 1	Town, State
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t P. rtani		' 4 □ Donation 5 □ Other (Specify		narin			3					F1D •
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VITAI iiclan: Ti certificate rector, pa	Be	25. Was case referred to medical	•				26. Pla	ce of Death	(Check only o		12.103	20110
ysic ysic is ce direc	70 1	examiner? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	Hospital: 1 💢npatient	2 □ ER/	Outpatient	3 DOA Ott					6 □Other (Speci	6.)
		27. Manner of Death	28a. Date of Injury (Month, Day)		. Time of	28c. Inju. Wo	ry at	2	8d. Describe h	ow inju	ury occurred	197
INISION (I or Attending I after death. Director: After I in by the funer	율	1 Natural 5 Pending 2 Accident investigation	(Month, Day	rear)	Injury		rk? Yes 2.[□No				
Attendii death. ctor: A y the fu	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injun	y - At home,	farm, stree	et, factory, office		2	8f. Location /S	treet a	nd Number or Run	al Route Number
P set et	Certification:	4 Homicide	28e. Place of Injury building, etc.	(Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Ton	m, Stat	te)	a. 7 10010 710/1100/,
Hospital Hospital Puns a Funeral i tely filled		29a. Certifier 1 Certifying Phy	sician: To the best of	my knowled	an death	anguered at the tr	ma data s	and place o	mel elum an abou		- \ d	
DIVISIO To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the f	Medical	(Check only 2 Medical Exam	iner: On the basis of e	xamination :	and/or inve	istigation, in my o	pinion, de	ath occurre	nd due to the t d at the time, o	ause(s date an	s) and manner as s id place, and due t	stated. o the cause(s)
thin thin mple	Me	29b. Signature and title of certifier	and manner state			29c. Licens	a number			20d D	ata airrad (Manth	One Variable
F 3 F 8		() ()	wlas- M	0							ate signed (Month,	Day, rear)
			-ijacy -			D29	120			9/	15/04	
П		30. Name and address of person who o	ompleted cause of dea					:				
1		15 Kustagi	mp 61.	32 L	ANICH	over Re	d C/1	cuarl	y md	义	0785	
Sta		31. Date filed (Month, Day, Year) NOV 0 5 2	32. Registrar'	s Signature	E.	-						
Registr	11	17 C U V U D Z	JU4 X2000			Ana.	100					

State of Maryland / Department of Health and Mental Hygiene [] [] [4 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year CANADA. GERAL DINE 24 10 3:45 ₽^M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK BEVERLY HEALTH CARE FREDERICK, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XX 578-36-0442 75 Director Nov 22, 1928 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatih and Mental Hygiene. ant of Heatih and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23a or 28a-1 show arry or other traumatic event, the Medical Examiner must be natified at Director 1 TYes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Angelwing Lane 21703 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Green Edna Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Canada (Son) 717 Angelwing Lane, Frederick MD 21703 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify)

21. Signatus 1 Funeral Service Light ee Chesapeake Crematory 10/25/2004 Beltsville, NO 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 art1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure nmediate Cause (Final Priysician FAILURE 10 TH RIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MENING LOMA. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit INSULIN - DEPENDENT DIABETES or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Box 68760 Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. CHRONIC INS U FFICIENCY. NEWAL 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ♠ No Certification: To s after death.

I Diractor; After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4795/ 10-24-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 TOLL HOUSE AUE FREDERICK, MD 21701. A. KAZMI, M.D

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

OCT 2 5 2004

Registrar's Signature

	770		1 - State of Mar State of Mar	yland / Depa <i>Cer</i>	artment of Health a	and Mer	ntal Hygien	2004	35183
	Physicia		Decedent's Name (First, Middle, Last) MICHAEL ANTHONY COFFMAN				Date of Death Month D Ctober 1	ay Year 9, 2004	3. Time of Death 11:50 P.M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) R (Branch Ave) south of Suratt		4b. City, Town, or Location of		4	c. County of Death	1
	Funeral Director			(In yrs. last birthday) 22 Yrs.	If Under 1 Year If Under Months Days Hours	Min.	Date of Birth (Month, Day, Yea ay 5, 198	r) 9. Birth Cou 32 Cheve	orge's oplace (State or Foreign untry) erly, MD
	Maryland -f show	tor		10c. City, Town or Lo Waldorf	cation				10d. Inside City Limits 1 ☐ Yes 2 No
	with the 3a or 28s	Director	10e. Street and Number 4750 Young Road		10f. Zip Code 20601			Citizen of What Cou	intry?
30	s I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. I fleat I stans 23a or 28a-f show other treumatic event, it is Moulant treumatic event, it is Moulant treumatic event.	by Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ev Armed Forces? 1 Yes 2 Mo		Was Decedent of Hispanic Ori f Yes, specify Cuban, Mexican I Tes 2 X No Specify:			14. Race - Amer Black, White	
212-0036	ithin 72 hour ne. nen "naturel	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mos. DO NOT use retire)		16b.	Kind of Business/li	
ryland 21	d be filed within antal Hygiene. ced other than " c event, the Ma	Be	12 17. Father's Name (First, Middle, Last) Michael Coffman	To		er's Name (F	irst, Middle, Maide Schick	Private on Sumame)	Company
Z	and 2 should be lealth and Mental m 27 is marked her treumatic ev	To	19a. Informant's Name/Relationship (Type, Print) Nicole M. Coffman - Wife		ng Address (Street and Number) Young Road,	er or Rural R	oute Number, City	or Town, State, Zi	ip Code)
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	TrinityMem	sition (Name of natory or other place) orial Cemetery 1		2004 Wa	Location - City or T $1 m dorf$, $ m M$	aryland
Ball	permit Depart Import any in		21. Signature of Funda Service De 1994	47	Name and Address of Facility 739 Baltimore	Ave.,	Hyattsvi		20781
	Pnysician /Medical Examiner		23a. Part1, Enter the disease, or complication, that caused the shock, or heart failure. List only one see on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a death)	d Inju	1	cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	rate be executed hysician and the buriat-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):					
рох 68/60	ding p	n/Medical	IF FEMALE: 23b. Was decedent pregnant					23d. Date of deliv	very
P.O. BQ	0 0 0	Physician/Med	in the past 12 months? 1 Yes 2 No 4 Pregnant at tir 9 Unknown 9 Unknown	me of death 5□	JEctopic pregnancy Other (specify)			Month	Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.			.1	the cause of death? bably 4 Unknown
Vital Records,	The ate h page	e Compieted	25. Was case referred to medical		00.01		24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
OT VI	Physicien; this certific al director,	ToB	examiner? 1X Yes 2 No Hospital: 1 Inpatient		t 3 DOA Other: 4 Nu	ursing Home			ity) At scene
Division	or Attending Physicien; ifter death. Director: After this certific in by the funeral director,	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Maccident investigation 3 Suicide 6 Could not be	11:35	PM 1□Yes 2□	No Ope	erator inju		ucle
Z	ospitel or At hours after of unerel Directly filled in by	O	4 Homicide determined 29a. Certifier (Check only 20a. Certifier (Check only 20a. C	my knowledge, death	n occurred at the time, date an	nd place, and	City or Town, Sta	s) and manner as	Mo Eurnshaw Mo stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	one) and manner state 29b. Signature and title of certifier	id.	29c. License number		29d. D	ate signed (Month,	, Day, Year)
R	0		30. Name and address of person who completed cause of deal Pamela E. Southall, M.		Print) 11 Penn Street	t, Bal		ober 20, Maryland	
	Sta Regista		31. Date filed (Month, Day, Year) 2. Registrar'	's Signature		-, -		- June	CICAT
-	411470 46	004							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0014 35184 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 20, **Physician** 2004 9:00 P CANIGLIA THERESA EMILY /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Waldorf

Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Charles 833 Barrington Drive If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months 1 M 20XF 84 Yrs. 1920 RHODE ISLAND MARCH 14, Director 039-03-4775 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It has a 23 e or 28s-1 show other treumstic event, the modified at other treumstic event, the Medical Examination and the confilied at 1 Yes 2 No Director WALDORF CHARLES MARYLAND 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20602 UNITED STATES 833 BARRINGTON DRIVE Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 TNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 1 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONCRETE COMPANY 12 OFFICE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ELLA DeRIA GIOVANNI DeCHARA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O.BOX 618, BRYANTOWN, MARYLAND 20617 KENNETH U. CANIGLIA - SON DRIVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot once. OCTOBER 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) HUNTT CREMATORY 25, 2004 WALDORF, MARYLAND 21. Signature of Funeral Service License P. O. Box 156, Waldorf, MD 20604 M00053 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIANCE Physician /Medical Examiner E AMONE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day õ 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 3 Probably Unknown 1 ☐ Yes 2 ☐ Ño been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page certificate 2 5 No 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) Certification: 28c. Injury at Work? After 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

31. Date filed (Month, Day, Year) State OCT 2 2 2004 Registrar

Dr. George H. Wathen,

30. Name and address of person who completed cause of death (Item 2 in Type, Print)

29b. Signature and title of certifier

11345 Pembrooke Sq. #103, Waldorf, MD 20603

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

					a. y.a.		rtificate		Death		200	14 3	5185
	Discontinuit		1. Decedent's Name (First, Middle,	Lest)						2. Dete of Deat Month		3. Year	Time of Death
	Physici /Medic		Daniel Carens C							October			:00 p.m.
	Examir	er	4a Fecility Name (If not institution,						b. City, Town, or Lo		4c. County		
	F		Fairfield Nursi 5. Social Security Number 6		e (In vrs.	lest birthdey)	If Under 1	Year	rownsvil			Arundel	(State or Foreign
	Funeral Director		036-18-1270 Usuel Residence of Decedent	X □M 2□F	82		Months [Days	Hours Min.	8. Date of Birth (Month, Dey, Oct. 30	, 1921	Country) Massach	(State or Foreign husetts
	yland		10a. Stete 10b. County		10c. Cit	ty, Town or L	ocation					10d. Ir	nside City Limits
	Marf si	ctor	Maryland Prince	Georges	Bowi	.e						1	Yes 2□No
	Aith th	Dire	10e. Street end Number				10f. Zip Co				0g. Citizen of V	What Country?	
	s 23s	erai	8509 Church Lane	12. Was Decedent	Ever in 11	C 12	2072		anania Origina (Ca		.S.A.	e - American In	odian
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than *natural', or items 23a or 28a-f show appringury or other traumatic event, the Medical Examinar must be noritied at once.	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces?	No		If Yes, specify	Cuba	spanic Origin? (Spanic Origin?) n, Mexican, Puerto Specify:	Rican, etc.)	Blac	White etc.	Ministry,
2-0	72 ho	eted	15. Decedent's (Specify only highest)	Education grede completed)		16e. Dece	dent's Usual (Occupe done a	etion luring most of works)	ing [[16b. Kind of Bu	usiness/Industr	Maryland
121	within	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	5+)				strator			ge Park	-
ο Ο	filed v Hygie offher 1	ပ္	17. Father's Neme (First, Middle, La	st)		Concre	- ICC Hain		18. Mother's Name	(First, Middle, M	Maiden Sumen	10)	
an	lid be lental ked o	To Be	Thomas J. Cashma						Mary E.	Carens			
ary	should be man		19a. Informant's Name/Relationship			19b. Maili	ng Address (S	Street a	and Number or Rura		City or Town,	Stete, Zip Cod	(e)
Σ,	ealth n 27 i		Robert Michael C	ashman Sr.,		-			ane Bowie	Annual Control			
ore	it of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		20b. F	cemetery, cre	osition (Name matory or othe	or or place				City or Town, §	
豆	it. Pa intmer intent: injury		4 □ Donation *5 □ Other (Spe 21. Signature of Fuperal Service Lice	• • • • • • • • • • • • • • • • • • • •	Hur		ematory		1^{\cdot} is of Fecility Rob	0/20/04			
Ba	Demi Depa Impo any ir		> KMA	011300					olis Roa				
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lir	the deat	h. Do not en	ter the mode o	of dying	, such as cardiac o	or respiratory arre	est,	Inter	roximate rval Between set end Death
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	a. Coub	TUA.	Laulin or es e conse	Q (CLG	list			/ Y	nouth
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~	rificate be executed ng physician end es the bunal-trensit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (d	or es e consec	quence of):						
68760,	ite be iysicia he bur	Ical	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (o	r as e consec	quence of):			-			
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P.O. Box	eath c	by Physician/	Datil Other Leiding			March Alexander			- I- B I	OOF DISE		1	4 4 4 9
Ö.	t tha d by the tachec	hys	Part II. Other significant conditions	.,	1		nderlying caus	se give	en in Parti.		bacco use con os 2⊡ No	3 ☐ Probably	cause of death? 4 ☑ Unknown
	as tha igned ba da	by P	Dementia, 1	Typo thy red	lum	!							7
Records,	The law requires that the death certificate be executed at a has been signed by the ettending physician end page 2 should be datached for use as the bunal-trensit	Completed		// V						24a. Was ar perform		available	utopsy findings e prior to tion of cause 1?
	The Data h	Con						_		1□ Ye	5 2 No	1 ☐ Yes	s 25 No
Zi Zi	Physician: r this certific arel director,	B	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of Death				===
ō	Phys r this arel dia	2	1 ☐ Yes 250 No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, De)		ER/Outpatier 28b. Time o		Injury	4 A Nursing Ho	me 5 🗆 Reside 28d. Describe ho			
on	Attending or death. •ctor: After by the fune	atlor	1 Natural 5 ☐ Pending 2 Accident investigat		Year)	Injury	м		:? ∕es 2 ☐ No		. ,		
Division of Vital	i or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At he c. (Specif	ome, farm, str	reet, factory, o	ffice		28f. Location <i>(Sti</i> City or Town		вг or Rural Rou	ite Number,
	To the Hospital or Attending Physician: The law within 4-burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)	Physician: To the best of aminer: On the basis of and manner ste	examina	wledge, deetl tion end/or in	n occurred at t vestigation, in	he tim my op	e, date end place, a inion, death occurre	and due to the ca ed at the time, da	use(s) and ma ite and place, a	nner as stated. and due to the o	cause(s)
	To the Within To the	M	29b. Signature and title of certifier	and married die			29c. L	icense	number	29	d. Date signed	d (Month, Day,	Yeer)
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		ļ	30. Neme and address of person wh	o completed cause of de	eath (Iten	1 23e) (Type,			_	1 40 5 50		7	1100.2
			31. Dete filed (Month, Dey, Yeer)	No h Jich	er's Signa	1415	Minopo	de	Road	#100	Och	4/04 1	MD21113
	Sta Registr		V @ A	2004	o oigila	K A	harth)						

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Detober 4017M RUTH DAVIS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lunts Fiam Mny Year If Under 24 Hrs. 5. Social Security Number If Under 1 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 25 TF Director 578-44-7734 71 May Wash. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23a or 28a-f show the Medical Examinations be notified at 1X Yes 2 No Directo D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 Morton Place, N.E. 20002 Funerai United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene. ant: If item 27 is marked other then "naturel", or Ites 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Beautician Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be McKinley H. Davis Christine Davis ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1850 Eagle Court Diane Stiney / Daughter Severn, Md. 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Himportant: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) National Mem. Park 10-30-04 Laurel, Md. 21. Signature of uneral Service Licensee 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002 23a. Parf. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit 9 resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2No 3 Probably 4 ☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 1 Yes Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA this Da of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred T Satural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2 5 2004 Registra

State of Maryland / Department of Health and Mental Hygieney = For State Registrar 35187 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician October 18, 2004 WILLIAM THOMAS DAVIS Jr 2:12 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 1129 Harvard Road Waldorf | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year | DEC 31, 10 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** X M 2 F Yrs. 1936 Washington, DC Director 578-48-4207 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner nast be notified at 1X Yes 2 No Maryland Charles Waldorf Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23a USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a any jnjury or other traumatic event, the Medical Examples 200. 20602 1129 Harvard Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑1Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 3 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Asbestos Installer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thelma Clarke Davis William T. Davis Sr ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia A. Davis (wife) 1129 Harvard Road Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buris 2X Cremation 3 Removal from State Metropolitan Crematory 10-22-04 Alexandria, VA * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eberwein Funeral Services M00173 4433 White Pls. 1a. White Pls., MD 20695 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY ARREST Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical SEVERE CHRENIC OBSTRUCTIV AIR WAY DISEUSE. **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Y FIBROSIS or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No : After this certifical funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending within 24 hours after death.

To the Funerel Director: Aft 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (chack only one) the of cer 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D57708 October 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abbas A. Omais, M.D. 7 Post Office Road Waldorf, MD 32. F. gistrar's Signature State 2004 Registrar

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment ertificate			and Me		giene	004	35188
	Physici	an	1. Decedent's Name (First, Middle, Last)			-	-			2. Date of De	ath Day	Year	3. Time of Death
	/Medic	al	Carolyn M. Diehl			1 1 Ci T		1		10	22	40	03:52 AM
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	Lat	46. City, 1	cown, or	Location o	Death		40.	County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthday) If Under 1		If Under		8. Date of Bir	th to More	9. Birth	polece (State or Foreign
	Director			M XXF	93 Yrs.	Months	Days	Hours	Min.	9M23_01	×9 7°4"	PA	intry)
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	Many India	tor	PA Bedford		Hyndman								1 ☐ Yes XXNo
	th the or 28a e cott	Director	10e. Street and Number			10f. Zip (-	on of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examinet must be notified at	rai	2056 Hyndman Roa			155					USA		_
	ler de Items Iner IT	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 □ Yes 🗷	Ever in U.S. 13.	Was Decede If Yes, speci	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spec i, Puerto P	cify Yes or No Rican, etc.)	- 14	I. Race - Amer Black, White	
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lan		To Be	Robert (mnu) Lab	vin						iu) Hop			
Maryland 21215-0036	sh and is m		19a. Informant's Name/Relationship (Ty) L. Robert Diehl	oe, Print)		-					-	Town, State, Z	ip Code)
	1 an Heal em 2 ther		20a, Method of Disposition		205. Place of Disp					lman, P		545 ation - City or 1	own. State
TOT	of of		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Sunset				10-29	-2004			
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Fu eral Service bicense	90		2. Name and				2001	Count	ocuna	, 1410
8	205 3		Leu	9								, Hynd	man, PA
			23a. Part : Enter the disease, or complishock, or heart failure. List only on	cations that caused e cause on each li	ne.		1	1					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1/CUL	e Myo	culd	1a	11	nKa	vch	211		3 0441
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	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	, ,	-51						7
	ecuted and -transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last		a consequence of);								_
8760,	death certificate be executed estending physician and ad for use as the burial-transit			Due to (01 a3	a consequence or).								
687	ificate g phys as the	edicai											
Вох	death certifica attending pt d for use as t	M/us	230. Was decedent pregnant	3c. If yes, outcome		⊒Ectopic pre	nnancy				23	d. Date of deliv	- /
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Ρ.	requires that the reen signed by th hould be detache		Part II. Other significant conditions con	tributing to death b	ut not resulting in the i	underlying car	use give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
rds	quires n sign	ed by								101	es 🗶	No 3□Pro	bably 4 Unknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe	p.		(Check only o			
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ion	Attending ir death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury	м	Work	? 'es 2 □ N	No				
Division	tal or Attending PI s after death. al Director: After tl ed in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At home, farm, st c. (Specify)	reet, factory,	office	<u>-</u>	28	3f. Location (S City or Tox		Number or Rui	al Route Number,
0	oital or urs afte aral Dir												
	To the Hospital of within 24 hours after the Funeral D completely filled in	Medical	29a. Certifier Certifying Physical Check only one)	ician: To the best ter: On the basis o and manner st	of my knowledge, dea f examination and/or in ated.	in occurred at ivestigation, i	t the time in my op	e, date and inion, deat	place, ar h occurred	nd due to the o d at the time, o	cause(s) aidate and p	nd manner as : lace, and due !	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	_		29c.	License	number			29d. Date	signed (Month,	Day, Year)
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	MAS		30. Name and address of person who co DR. Robert Rapp	mpleted cause of o	leath (Item 23a) (Type DRIVE. (Print)							
	Sta Registr		31. Date filed (Moath, Say Year) 0C 1 2 6 2004	32. Registr	ar's Signature	Spark							

			For Stata Registrar	State of M	aryland / [Depa <i>Cer</i>	artment of Hea <i>rtificate of De</i>	alth and M e <i>ath</i>		gier ie Reg. No.		35189
	Dhysiair		1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	ath Day	y Year	3. Time of Death
	Physicia /Medic		Dona1d		ank]	Decker		10	19	204	00:50
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, or Loc	cation of Death		4c.	County of Dea Allego	
	Farmer		Sacred Her 5. Social Security Number		e (In yrs. last bii	rthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birt	h	9. Bir	tholace (State or Foreign
	Funeral Director		215-26-6580	tXXM 2□F	72	Yrs.	Months Days H	Hours Min.	04/21/	1932	Ma	ountry) ryland
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lo	nation					10d. Inside City Limits
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	28a-f	Director	10e. Street and Number	Legany		Cui	mberland 10f. Zip Code			10g. Cit	izen of What Co	ountry?
	3a or	Ö	545 Winifred	Road			21502	2		U	SA	
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spe	ecify Yes or No-	-	14. Race - Ame Black, Whit	
36	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "natural", or tems 23a or 28a-f show event, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Marri	ed 1XXYes 2 If Yes, Give	№1953 -		_ ***	Specify:	, , , , , , , ,		Specify:	
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Maryland	should be f and Mental I s markad of umatic eva	ဥ	19a, Informant's Name/Relationsh				ng Address (Street and		May	,	or Town State	
Z	permit. Pages 1 and 2 should be Department of Health and Menia Important: if item 27 is marked any injury or other traumatic evonce.		Carol J. Decker				Winifred Ro					.502
Baltimore,	ss 1 ar		20a. Method of Disposition		cometa	of Dispo	sition (Name of matory or other place)	0	ate	20c. Lo	ocation - City or	Town, State
E	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp			rla	nd Cremato				berland	
3alt	epartr epartr nporta ny inje		21. Signature of Funeral Service I			1						Home, P.A.
	20E 3 0		23a. Part1. Enter the disease, or	allem	d the death. De		404 Decatu		<u> </u>		na, MD	21502 Approximate
			shock, or heart failure. List	only one cause on each l	ine.		•	_		rest,		Interval Between Onset and Death
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	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		-4)						
60,	be execian a	EX	1650ttelg in death) Last	Due to (or as	a consequence	01):						
68760,	physi s the t	edicai		d								
Box (n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Je . ·				23d. Date of de	livery
	The law requires that the death certil ste has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetel death it time of death		Ectopic pregnancy Other (specify)				Month	Day Year
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Rec	ne lav e has ge 2 :	mp							autop perfo	rmed?	prior to death?	completion of cause of
ta		a	25. Was case referred to medical				26	6. Place of Death		2 No	1 L Yes	3 2 □ No
Ž	Physician: The la vrthis certificate has sral director, page 2	To B	examiner? 1 □ Yes 🐉 No	Hospital: 152 Inpati	ent 2 ER/O	utpatier	Other	4 Nursing Ho			6 □Other (Spe	ecify)
0	Attending Physician: Ir death. ector: After this certifici by the funeral director.		27. Manner of Death Natural 5 ☐ Pendin	28a. Date of Injugation (Month, Date of Injugation)		Time of Injury	Work?		28d. Describe h	now injui	ry occurred	
sio	tendil leath. lor: A the fu	cati	2 Accident investig	gation	As bassa 6			2 □ No	ODE Lanation /6	Ctro at a s	ed Alumbas as (7	and Boute Marries
Division of Vital Records,	in Direct	Certification:	4 Homicide determ	ined 200. Flace of in	tc. (Specify)	arm, str	reet, factory, office		City or Tox			ural Route Number,
_	spital		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledg	e, deati	h occurred at the time, o	date and place,	and due to the	cause(s)	and manner a	s stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner st	of examination ar	nd/or in	vestigation, in my opinio	on, death occurr	ed at the time,	date and	d place, and due	e to the cause(s)
	m	Z	29b. Signature and title of certified	111 2 2			29c. License nu	umber			te signed (Moni	
(:	5),		- Hoof	Jun 2			060	4/6	0	Vcl	19.8	2004
1-	noh		30. Name and address of berson	who completed cause of AVe. (02	/		Print) Afair	,	2150 =			
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	11 De	- novia	11/	-130	,		
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			1- State of Maryland / Department of Health and Mental Hygiene 2004 35/9
ľ	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / Day Year 3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Modical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 I M 2 DF 6. Yrs. 6. Yrs. 6. Sex 7. Age (In yrs. last birthday) 1 I Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Country) 9. Birthplace (State or Foreign Country) Country) Country)
	p .	o.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits
	with the Maryland s or 28s-f ehow	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
350	in 72 hours after death with the Marylar n'naturel', or items 23e or 28e-f ehow tedicial Esai: a wr must be neithed at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Secrify: Uhite 14. Race - American Indian, Black, White, etc. 1 Specify: White
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ylana z	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Tuddie Dages Jones Effice May Kelley
ore, mar	ges 1 and 2 should t of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number). City or Town, State, Zid Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Daltimo	permit. Pege Department Important: fl eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Column OF Service Licensee 23. Signature of Funeral Service Licensee 24. Name and Address of Facility Lee Funeral Home Column OF AP 25. Serthern Manyland Blod. County My 2013
¥.	Physician /Medical		23a. Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cardiac Arrhythmia. Cardiac Immediate Cause (Final disease) The proximate of the mode of dying, such as cardiac or respiratory arrest, and service of the caus
8/00,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
O. Box 6	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Ectopic pregnancy Month Day Year 1 ☐ Ectopic pregnancy Month Day Year 1 ☐ Ectopic pregnancy Month Day Year 1 ☐ Ectopic pregnancy
7	equires that i sen signed by ould be deta	þ	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Find Stage Chronic Obstructive Air Way disease 1 Tyes 2 No 3 Probably 4 Unknown
Vital Records,	The lay ate has page 2	e Completed	Corpulmenale Respiratory Failure 24a. Was an autopsy perior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
or vii	Physicien: this certific ral director,	ToB	examiner? 1 Yes 2 No
DIVISION	tending Physicien: Jeath. tor: After this certific the funeral director,	Certification:	27. Manns- of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
2	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		4 Homicide determined determined building, etc. (Specify) 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 289. Cocation (Street and Number or Rural Houte Number, City or Town, State)
	the Hosp in 24 hol the Fune ipletely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	то тоо	N	29b. Signature and title of certifier Eyew. C. Swrang. 29c. License number 29d. Date signed (Month, Day, Year) 10-21-2004
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN. C. SURANA 5851. Deale Churchton Roced. Deale. m.p. 20757
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 2 2004 Meney H. Anaell 8

		1- For Amend Item1&Unpend Item/23a, pt. 129, 28a Health and Certificate of Death	Hesigh Hy	919 35191
		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath 3. Time of Death
Physic /Med		Robert Gordon Fields Jr.	Month OCTOBE	R 28. 2004 7:00a M
Exami		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of De SALISBURY	eath	4c. County of Death WICOMICO
Funeral Director		219-56-8457 ADM 2017 52 Yrs.	in. 4 2 0 Parts	9. Birthplace (State or Foreign Country) Maryland
pu s		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Aaryla F sho	ŏ	Maryland Wicomico Salisbury		1 ☐ Yes 2X No
ith the Marylan or 28a-f show	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
3a or		2323 Hudson Drive 21804		USA
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "naturel, or items 23s or 28s-1 show ont, the Maulcal Expedient mant ten nutilised at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
in 72 hours att	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of with the properties of the properties	working	16b. Kind of Business/Industry
212 d with giene.	E	1 1 College (1-4or 5+) HVAC Technician	1	Heating/AirConditi
filed filed other vent,	Be C		Name (First, Middle,	
rlar uld be Menta rked rked	TO B	Robert Gordon Fields Sr. Mary	E. Will:	iams
re, Maryland 21215-0 s 1 and 2 should be filed within 72 ho Health and Mental Hygiene. item 27 is marked other than "natur other treumatic event, the Madical	ľ	19a. Informant's Name/Relationship (Type, Print) Robert G. Fields Sr./father 231 Cedar Way,		
Baltimore, Ma permit. Pages 1 and 2 s Depertment of Health ar Importent: if item 27 is any injury or other treu once.		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 1 Donation 5 Other (Specify) SalisburyCrematory 1	Date	20c. Location - City or Town, State
Baltin permit. P Depertme Importen any injuri		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		
m 83555	<u> </u>	23a. Part1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Hypertensive Atherosclerotic Card	Rd., Sal:	isbury.MD 21804
8760, cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
Box 6 death certifice attending of for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 Compared to the pregnancy 1 Compared to		23d. Date of delivery Month Day Year
cords, P.O w requires that the s been signed by th should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus		obacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ☐Unknown
Rec	Completed by		24a. Was a autop:	sy prior to completion of cause of
of Vita Physicien: this certific ral director,	Be		Death (Check only or	
Phys this a	2			lence 6 Other (Specify)
on of ding Phy th. After thi funeral	lon	1 Natural 5 Pending (Month, Day Year) Injury Work?		
iSiG ttend death ctor: / the	lcat	6 Could get be	Subject 28f. Location (S	
Div	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital	Hospita	Greet and Number of Rural Route Number, m. State) Deer's Head I Center Salisbury, M
Division o To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the component of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the basis of examination and/or investigation, in my opinion, death occurred at the basis of examination and/or investigation, in my opinion, death occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of e	ace, and due to the c	cause(s) and manner as stated.
To the within To the comp	Me	29b. Signature and title of certifier Carol Hallau Ma 29c. License number OCME		29d. Date signed (Month, Day, Year) CTOBER 29, 2004
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Ba	altimore,	Maryland 21201
S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 0 1 2004 32. Registrar's Signature Sports		

			For State Registrar	State of	Maryland		artment of H			giene 00	4 35192
	Physicia		Decedent's Name (First, Middle, KIRS LYNN KY)		NYETTE	FEDE	CRICK		2. Date of Dea Month OCT	_	3. Time of Death 10:20 A _M
	/Medic Examin		4a. Facility Name (If not institution, NATIONAL NAVAL	give street and numb	ber)		4b. City, Town, or BETH	ESDA	th	4c. County of	Death NTGOMERY
	Funeral Director		212 71 8280 Usual Residence of Decedent	1□M XXF	. Ago (m yrs. rag	Yrs.	Months Days	Hours Min	AUG. 31	r, rear)	9. Birthplace (State or Foreign Country) MARYLAND
	Maryland	tor	10a. State 10b. County	GEORGES		Town or Lo					10d. Inside City Limits XIX Yes 2 □ No
	with the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene marked other then "leturel", or Items 23e or 28e-f show imetic event, the Medical Examinar must be rediffed at	by Funeral	5604 62ND AVENUE 11. Marital Status XX Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced	IX No		Was Decedent of H f Yes, specify Cuba 1 □ Yes XX No	0737 ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. BLACK
Maryland 21215-0036	within 72 hour ne. :hen "neturel :he Medical Ex	Completed t	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	orking	16b. Kind of Busi	iness/Industry
and 5	m = 0 %	To Be Co	OYRS. 17. Father's Name (First, Middle, La D*ANDRE LAWSON	est)	<u> </u>		N/A		ume (First, Middle,	,)
lary	2 should and Men is marke eumetic	F	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailir	ng Address (Street				tate, Zip Code)
altimore, N	Pages 1 and nent of Health int: If item 27 iry or other ti	Charles Control	TA NYETTA FEDER 20a. Method of Disposition 1 Burial XX Cremation 3	□Removal from S	20b. Placentate	ce of Disponetery, crer	62ND AVE sition (Name of natory or other place	:8)	Date	MD 207:	
Baltin	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked eny injury or other treumetic en		4 □ Donation 5 □ Other (Spe 21. Signature of Fuperal Service Li		METR	22 MA	TAN CREM. Name and Addres RSHALL'S OS SUITL	ss of Facility FUNERAL	HOME O	F MARYLAI	DRIA, VA ND,INC. MD 20746
×	Physician		23a. Part1. In er the disease, or c shock, wheart failure. List of Immediate Cause (Final disease or condition	omplications that ca nly one cause on ea	used the death. ch line. RENAL F	Do not ent	er the mode of dyin				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a conseque		IATURITY				
8760,	ate be executed hysician and the burial-transit	al Examiner	Sequentially list conditions, If any leading to without a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseque	nce of):	EXIONEII				
.O. Box 687	The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		th 2 ☐ Fetal d nt at time of dea	eath 3	Ectopic pregnancy Other (specify)	,		23d. Date Month	•
<u>α</u>	quires that t in signed by uld be deta	by	Part II. Other significant condition	s contributing to dea	ath but not result	ing in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
Vital Records,		Completed							24a. Was autop perfor 1 \sum Yes	sy priemed? de:	ere autopsy findings available or to completion of cause of ath? ☑Yes 2☐ No
Vita	Physicien: The rathese cartificate ral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2X No	Hospital:	patient 2□El	R/Outpatier	it 3 DOA Oth	00	eath <i>(Check only on</i> Home 5 Resid		(Specify)
ion of	a = D		27. Manner of Death 1 Xatural 5 Pending 2 Accident Investiga	28a. Date of (Month		8b. Time of Injury	28c. Injun Wor			ow injury occurred	
Division	or after	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 288. Place	of Injury - At hom g, etc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	he Hospitel in 24 hours in he Funerel pletely filled	edical		Physician: To the to keminer: On the bas and manne	sis of examinatio						ner as stated. d due to the cause(s)
į.	To the within 2 To the complet	M	29b. Signature and title of certifier	2.1	D 1	11	29c. Licens MD 04		(PA)	29d. Date signed ((Month, Day, Year)
	2(1)		30. Name and a dress of person w			(Type,	Print)	NATIONAL	NAVAL MI		TER
1	Sta Regist		MAUREEN L. TAT 31. Date filed (Month, Day, Year) OCT 2 2 2	32 . Re	C USA gistrar's Signatu	re An		ου τυσουΑ	עוז 2008)	9- 2000	

			For State Registrar	State of Ma	aryland /	Depa Cer	irtment of H	lealth a	and Me	ental Hygie	ene20()4	35193
			Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death
E	Physicia /Medic		Joanne Fitzgerald							Month October		Year)4	8:45 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location (4c. County o		
ı			905 Blueleaf Court	, Unit B			Frede				Frede	eric	k
	Funeral Director		149-28-18/3	7. Ag	e (In yrs. last 66	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. M	B. Date of Birth (Month, Day, 1 arch 8,	1938	9. Birthp Cour Nev	place (State or Foreign htry) VYork
	pur A		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					1	Od. Inside City Limits
	faryli	ō		1.									1 Yes 2 No
	the h	Director	Maryland Frederic 10e. Street and Number	K	FI	eder	10f. Zip Code			10	g. Citizen of WI	nat Cour	ntry?
	3a or	Ö	905 Blue Leaf Cour	t. Unit B			2170	1			United		•
	me 2	Funeral	11. Marital Slatus	12. Was Decedent		13. \	Vas Decedent of Hi f Yes, specify Cuba		igin? (Spec	ify Yes or No-	14. Race	- Americ	can Indian,
36	permit. Pages 1 end 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23e or 28e-f show any injury or other treumatic event. If a Medical Evant must be notified at an	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	ł	r Yes, specify Cuba I□ Yes 2⊠ No	Specify:		can, etc.)	Specify:	, White, Wh	etc. nite
Maryland 21215-0036	2 hou	ted	15. Decedent's Edu		16	6a. Deced	lent's Usual Occupa	ation	at of working	10	6b. Kind of Bus	iness/In	dustry
215	thin 7	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	DO NOT use retired	during mos ()	a or working	'			
7	ed wil	Completed		5+		Reg	istered N				Healt		are
nd	be tild tal Hy d oth	Be	17. Father's Name (First, Middle, Last)							First, Middle, Ma)	
Σ	ould Men Marke	2	Meyer Brody							Plotki			
Nar	12 sh n and 7 is rr	0 3	19a. Informant's Name/Relationship (Ty				g Address (Street a						
e,	1 end Healtl em 2 ther t	1	Joanne Fitzgerald 20a. Method of Disposition	/ Self			lueleaf C				CICK, MI Oc. Location - C		
Baltimore,	ages nt of h : if ite		1 ☐ Burial 2 Scremation 3 ☐ F				sition (Name of natory or other plac	1	ctobe 20	1 23,			
誓	iit. Partiment printer	. 4	 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun ral Service Licens 		Rest		Cremato						aryland
Ba	Depa Impo any i		1 711 1			95	Name and Address Sthaven 1	tin m	tn. H	wy. Free	derick,	Cody MD	P.A. 21701
П			23a. Part1. Enter the disease of comp shock, or hear tailure. Eist only	nations that caused ne cause on each li	the death. D	o not ent	er the mode of dying	g, such as	cardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	POOR	LY Difi	cener	VATINTED	NON-	514192	LCELL	LUNG		10 MONTHS
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):					CATIN GET	2	,
	LAdimici	-	Sequentially list conditions,	b. — Due to (or as	a consequen	on off:							
	led sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or 23	a consequent	ce or,							
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequen	ce of):							
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189	ificate g phy as the	edic		v									
Вох	The law requires that the death certificate be executed as been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Completed by Physician/Me	230. was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				23d. Date		*
B.	death	sicia	in the past 12 months? 1 ☐ Yes 2 Z No	4☐Pregnant a			Other (specify)				Mont	h	Day Year
P.O.	that the de led by the a detached t	² hy	9 Unknowh										
	res tha igned be del	by	Part II. Other significant conditions co	ntributing to death b		g in the u	nderlying cause give	en in Part I	l.	1.4			ne cause of death?
ord	w require been si should I	ted			-					1)X Yes	2 □ No 3	☐ Prob	ably 4 \(\sum \text{Unknown} \)
Vital Records,	siaw nasb e 2 sl	npie	DEEP VEIN THE	274/30515						24a. Was an autopsy performe	pri	ere auto or to co ath?	psy findings available mpletion of cause of
E													2 No
Zii.	Physician: rthis certitic ral director.	Be	25. Was case referred to medical examiner?	Hospital:		-	• 3C DOA Othe	00		Check only one			-
	> 0 D	.T	1 Yes 2 No	28a. Date of Inju		Outpatien b. Time of	I SLI DOM	4 🗀 NU	ursing Home	e Residen d. escribe how	ce 6 Other		y)
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ă	atter i Dire	Certification:	4 Homicide	building, et	c. (Specify)					City or Town,	State)		
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely tilled in by the funeral.	edicai C	29a. Certifier (Check only one) Certifying Phy	sician: To the best ner: On the basis o and manner st	f examination	dge, death and/or in	n occurred at the time vestigation, in my op	ne, date an pinion, dea	nd place, an	d due to the cau d at the time, dat	ise(s) and man e and place, an	ner as s d due to	tated. the cause(s)
	o the	Me	29b. Signature and title of certifier	h ·			29c. License	e number		290	d. Date signed	Month,	Day, Year)
	->-0		> More MOC	more "	70		D3.	1761	/	4	10/22	104	
	i		30. Name and address of person who co		leath (Item 23	a) (Type,	Print)	-					
	P		BRIAN M. O'COM	was who	501	W. S	ENENTH	5/ -	FRE	DEPICK	MO	21,	101
	Sta		31. Date filed (Month, Day Year)	32. Registr	ar's Signature		1 .	7			/		
	Regist	ar	901 20	2004	epera	_/	9 500	216	,				

December State (Pint Mother Land June 1 June 1 June 1 June 2 Ju				State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygie	/1114	35194
James J. Flippo Sr.						2. Date of Death		3. Time of Death
## Facility News (First instations, give stress and name/or Annapol 1. Mone Arrunded 1. Mone Mone Arrunded 1. Mone Arrunded 1				James J. Flippo Sr.				12:32 A M
South Security Number Colore Colo				4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
226-20-52.17 78 vs. Months Days State Ms. No. No. 17, 1925 VITE In La								
The State 106. County 10				226-20-5217 1X M 2□F 78 Yrs.		8. Date of Birth (Month, Day, Ye Nov. 17,	9. Birth 1925 Virg	nplace (State or Foreign untry) ginia
23a. Part. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and continued a		and *		the state of the s	ocation			10d. Inside City Limits
23a. Part. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and continued a		Maryl f sho	ō	Maryland Anne Arundel Odenton				1 ☐Yes 2 ☐ No
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23a. Part. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and continued a	1	ithin 19.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9		
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23a. Part. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and continued a		Departm Departm mporte any inju		21. Signature of Fune al Service Licensee	2. Name and Address of Facility RO	ert E. Ev	vans Funer	al Home
shock, or hear failure. List only one cause or each line.		20200			-			
Due to (or as a consequence of): Cost of or as a consequence of):	d			shock, or heart failure. List only one cause on each line. Interediate Cause (Final Standard Cause) Mineral or cause (Final Standard Cause)	Seps15			Interval Between Onset and Death
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The standard devents a consequence of the standard of the stan			-	Sequentially list conditions.	James			
The part of the pa		nsif	mine	Cause (Disease or injury				
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30. Name and address of person who completed (cause of death (Item 23a) (Type, Print) Jacqueline Ryan 2001 Medical Park, Annapolis, Maryland 21401 State 31. Date filed (Month, Pay Year) 2001 32. P. Istrar's Signature		ysicia ysicia	cai	d				
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Jacqueline Ryan 2001 Medical Park, Annapolis, Maryland 21401				Jaiquelinis Kepu MI)	057078		10/18/20	104
State 31. Date filed (Month, Day, Year) 32. P. jistrar's Signature						ınd 21401		
				31. Date filed (Month_Day_Year) 32. Registrar's Signature	_			

N	0720		For State Registrar	State of M	larylan	-	artment tificate			and M		giene Reg. No	nni.	25105
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of Dea Month OCTObe	th	Year	3. Time of Death
	/Medic Examin	al	Galt Burns Grie 4a. Facility Name (If not institution, give		7)		4b. City,	Town, or	Location of	of Death	Octobe		2004 Unity of Death	1740 P M
	Examin	eı	9106 49th Avenue		,				Park			Pr	ince G	eorge's
	Funeral		5. Social Security Number 6. S 213-46-7418	ex 7. A ☑M 2□F	ge (In yrs. 1 58	ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 8,	h	9. Birtho	place (State or Foreign place) Lington, DC
	Director		Usual Residence of Decedent			113.					July 8,	1940	wasn.	Lington, DC
	arylanc show	_	10a. State 10b. County	_	,	, Town or Lo							1	0d. Inside City Limits
	the Ma	Director	Maryland Prince 10e. Street and Number	George's	C	ollege	Park					10a Citinaa	of What Cour	1 XYes 2 No
	3a or 3		9106 49th Avenue				101. Zip	207	40			U.S.		itry !
	deeth	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13.	Was Deced			gin? (Sp	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
36	or It	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates:	No	-	1 ☐ Yes 2			,			ecify: Whi	
9	72 hours after deeth with the Maryland naturel', or Items 23a or 28e-f show Jisal Exartreer mat be motified at		15. Decedent's Ed	ducation	· 	16a. Deced	ient's Usua	I Occupa	ition				of Business/in-	
215	within 7. ene. then "n	Completed	(Specify only highest gra	College (1-4or	5+)	life.	kind of wor DO NOT us —	e retired,)	t of work	ing			
121	e filed wall Hygier other the	Cor	17. Father's Name (First, Middle, Last)	3		Accou	nt Ex	ecut		ır's Namı	e (First, Middle,		Telep	hone
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours atter deeth with the Marylan it of Heatih and Mental Hygene. If item 27 is marked other then "naturel, or Items 23a or 28e-f show or other traumatic event, it a Marical Examinating and burnalities of the mailten and the mailten at the mailten and the mailten and the mailten and the mailten at the mailten and the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mailten at the mail at the mailten at the mailten at the mail at the ma	To Be	George Livingsto		uer						th Burns			
lary	2 should be n and Mental 1s marked of raumatic ev		19a. Informant's Name/Relationship (, ,			_				al Route Numbe	-		
	s 1 and 2 of Health a item 27 ls other trai	1	Grace G. Griesba 20a. Method of Disposition	uer - Wif		9106 lace of Dispo			nue,		lege Par		ryland	
Baltimore,	Pages nent of H int: If ite		1 ☐ Burial / ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific		9 C4	emetery, crer ropolit	natory or ot	her place						, Virginia
altir	-: 듣 만 :=		21. Signature of Fun tell Service in the		TREE						sch's Fu			-
m	Depa Impo any ii		- Tollet	.11e, M	D 20781									
			23a. Part1. Enter the disease, or comshock or heart failure. List only	olications that cause one cause in each	ed the death line.	n. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory an	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediat 'Cause (Final disease or condition resulting in death)	a. HA PERT			HE ROS	CLE	ROTIC	, clf	HRNIOVA			
	Examiner		Conventially list conditions	b	o a consequ	301100 017.						DISEA	126	
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	ence of):								
	xecute and ai-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	uence of):				-			-	
8760,	cate be executed physician and the burial-transit			d										
9	ing phy a as th	Physician/Medical	IF FEMALE:											
Box	death certific e attending p id for use as i	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 🗌 Fetal	death 3	Ectopic pre						Date of delive Month	ry Day Year
Ö.	0 0 0	hysic	1	9□ Unknown	at time or de	Juli 5_	10000	JUNY						
s, p	se us	by P	Part II. Other significant conditions of			ulting in the u	nderlying ca	ause give	n in Part I.					e cause of death?
ord	w requir been si should	eted	CEREBRAL	INFARC	(es 2 No		ably 4 hknown
Rec	e la has je 2	ompleted									24a. Was a autop	sv	prior to cor death?	psy findings available appletion of cause of
of Vital Records,		e C	25. Was case referred to medical						26. Place	of Death	1 X Yes	2□No ne)	1 X Yes	2 □ No
ž V	dis dis	To B	examiner? 1 (\$\frac{1}{2}\text{Yes} 2 (□) No	Hospital: 1 ☐ Inpat		ER/Outpatien					me 5 Resid			At scene
		:lon:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	M 28	Bc. Injury Work	at ? ′es 2.⊟l		28d. Describe h	ow injury oc	curred	
Division	ten feat tor: the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Ir	njury - At ho	me, farm, str	_			-	28f. Location (S	treet and Nu	ımber or Rura	l Route Number,
D	Dir	Cert	4 Homicide determined	building, 6	etc. (Specify	/) 					City or Tow	n, State)		
	Hora Para	edical		ysician: To the bes niner: On the basis and manners	of examinat									
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner s	stated.		29c.	. License	number		2	29d. Date sig	gned (Month,	Day, Year)
)	5		> auest 2_				(O.C.	M.E.			Octob	er 18,	2004
R	(10)		30. Name and address of person who	completed cause of	death (Item			Str	eet.	Balt	imore,	Mar _v 1.	and 21	201
	Sta	ite	31. Date filed (Month, Day, Year)		trar's Signat							- ALL Y L		~VI
	Registi	ar	OCT 2 2 200	14 Bleen	e d	ture for	West !							

re Green	± ±€.	State of Maryland / Der 1- For Amend Item 10d per FH, G842, 04/2	partment of Health and Mental I of Death	Hygiene 2004 35196
Physi		1. Decedent's Name (First, Middle, Last) ANDRE D. GREENFIELD	2. Date o Month OCT	f Death 3. Time of Death Ober 15, 2004 19:13 M
/Med Exam		4a. Facility Name (If not institution, give street and number) 1929 Brooks Drive #T-2	4b. City, Town, or Location of Death Capitol Heights	4c. County of Death Prince George's
Funera Directo	_	5. Social Security Number 5 7 8 9 6 0 7 6 6 Sex Y□ M 2 □ F 7. Age (In yrs. last birthda 3 0 Yrs.		f Birth , Day, Year) 9. Birthplace (State or Foreign Country) 6/1974 Washington DC
r 28a-f show	٥	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1		10d. Inside City Limits ¥☐ Yes 2 ☐ No
with the Ne or 28a-f	Director	D.C. Washin 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1215-0036 within 72 hours after death with the Maryland ane. then "neturel", or items 23e or 28e-f show the Maricel Exempter must be multified at	by Funeral	414 18th Street, N.E. #4 11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	20002 B. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1□Yes 2☒No Specify:	U.S.A. If No- 14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036 nd 2 should be filed within 72 hours affull and Mental Hygiene. 27 Is marked other then "neturel", or rtreumetic event, Its Marical Exami	Completed	(Specify only highest grade completed) (Git Flementary/Secondary (0-12) College (1-4or 5+)	sedent's Usual Occupation re kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry Private
be filed ttal Hygi d other	To Be Co	17. Father's Name (First, Middle, Last) Anthony Ashwood	18. Mother's Name (First, Mic Georgene	ddle, Maiden Sumame) Greenfield
Ore, Maryla ges 1 and 2 should t of Health and Men If item 27 Is merke or other treumetic		Tasheena Greenfield, Sister W	iling Address (Street and Number or Rural Route Nu B10 6th Street, 2 W position (Name of Date ematory or other place)	# 4 0 4 20c. Location - City or Town, State
timen rtent:	NIE STATE	*4 Donation 5 Other (Specify) 21. Signatu 8 1 Fungal Service Licensee	olitan Crem 10/27/0	4 Alexandria Va. ROTHERS FUNERAL HOME
Pnysicia /Medica Examine		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	onter the mode of dying, such as cardiac or respirato	Approximate Interval Batween Onset and Death
8760, sate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, any, leaving to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dise to (or as a consequence of): c. Due to (or as a consequence of):		
O. Box 63 ne death certific the attending p	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetef death 3 4 ☐ Pregnant at time of death 9 ☐ Unknown	B⊟Ectopic pregnancy □ Other (<i>specify</i>)	23d. Date of delivery Month Day Year
cords, P.(w requires that the been signed by should be detaction.		Part II. Other significant conditions contributing to death but not resulting in the	and the second s	Did tobacco use contribute to the cause of death? I □ Yes 2 □ No 3 □ Probably 4 □ Unknown
Vital Records, eicien: The law requires to certificate has been signe irector, page 2 should be or	Completed	25. Was case referred to medical	, a	Was an all all all all all all all all all
<u>→</u> S D	To Be	examiner? 1X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death (Check of other: 4 Nursing Home 5 F	
Division (or Attending latter death. Director: After tin by the funer	Certification;	27. Manner of Death 1	M 1 ☐ Yes 2 ☐ No 28f. Locatic	on (S reet and Number or Rural Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C		ath occurred at the time, date and place, and due to investigation, in my opinion, death occurred at the ti	th cause(s) an manner as stated. In date and Lice, ny ue to the ourse(s) 29d Date signed (Month, Dhy, Year
		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Typ	O.C.M.E.	October 16, 2004
KW	State	J. Jate filed (Month, Day, Year) 32. Registrar's Signature	Penn Street, Baltimore	e, Maryland 21201
Regi	strar	OCT 2 5 2004 See & A	orte .	
		ORIGIN	NAL	

			For State Registrer	State of Maryla	-	artment of I rtificate of			Reg. No.	004	35197
	Physici		1. Decedent's Name (First, Middle, La		busile			2. Date of D Month	Day	Year	3. Time of Death 0 548 M
	/Medic Examir		4a. Facility Name (If not institution, given				or Location of Deat	h	4c. Co	unty of Death	
			PENINSULA REGION		Center		1456414			Nicomi	
	Funeral Director			Sex 7. Age (In yr	rs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth 9ay, Year) 1922	Cour	place (State or Foreign http) rland
	yland Now		10a. State 10b. County	10c. (City, Town or Lo	ocation				1	Od. Inside City Limits
	a-fsh	ctor	VA Accomack		New Chu	ırch				į	1 Yes X No
	vith th	Dire	10e. Street and Number			10f. Zip Code				of What Cour	ntry?
	ns 23	eral	28326 Holland La	INE 12. Was Decedent Ever in	U.S. 13.	23415 Was Decedent of h		Specify Yes or N	US.	A Race - Americ	can Indian.
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene, tem 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event. Its Medical Exam are must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	an, Mexican, Puer Specify:	to Rican, etc.)		Black, White,	etc.
215-0036	within 72 ho ene. then "natur to Medical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking	16b. Kind	of Business/in	dustry
21	filed withi Hygiene. other then ent, the M		10		Farme	er	40.14.15.1.14	/ET		culture	2
Maryland	2 should be fill and Mental H Is marked off	To Be	17. Father's Name (First, Middle, Las Marion S. Hollar				18. Mother's Na Margare		e, Maiden Su	тате)	
Mar	12 shu h and 7 Is m Iraum		19a. Informant's Name/Relationship	, · · · · ·		ng Address (Street			-		Code)
re,	Health tem 27 other tr		Una Beach Holland 20a. Method of Disposition		Place of Disor	Holland		Date	1	ion - City or To	own, State
m 0	Pages ent of nt: If i		1 ■ Surial 2 □ Cremation 3 E '4 □ Donation 5 □ Other (Speci			matory or other pla Presbyteri	l l	6/2004	Pocomo	oke Cit	v. MD
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other 2002.		21. Signature of Funery Service Lice			2. Name and Addre		Funeral	Home,	P.A.	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the de one cause on each line.	eath. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory	arrest,	y , 1112 2	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_ a		Cou	32-1118	HICH	Sail	472	Onset and Death
ı	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):						
	ad sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	equence of):						
8760,	certificate be executed ding physician and use as the burial-transit	al Examiner	that initiated events resulting in death) Last	c	equence of):						
9	ifficate g phys as the	edical		d							
P.O. Box	death e atter d for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3[□Ectopic pregnanc □ Other (specify) _	у		23d	I. Date of delive Month	ery Day Year
	res that the igned by the be detache	by Ph	Part II. Other significant conditions	_	_						ne cause of death?
rds	w requires been sign should be	ed	Prisumania	Bhoumati	ord an	churs,	Burn	~40.41	Yes 2 1	lo 3 ☐ Prob	ably 4 Unknown
of Vital Records,	e law i has by ge 2 st	Completed	Vasculite						s an 2 opsy formed?	prior to condeath?	psy findings available mpletion of cause of 2 No
/ita	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only			
of \	Phys this al di	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie		4 🗆 Nursing r	fome 5 ☐ Res			γ)
O	fing After fune	tlon	1 Actident 5 Pending investigated	(Month, Day Year)	Injury	Wo	rk? Yes 2□No	Zou. Describe	TIOW INJURY OF	ccured	
Division	ol or Attendia after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not determined		t home, farm, st	reet, factory, office			(Street and Nown, State)	lumber or Rura	l Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier Certifying P (Check only one) 2 Medicel Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, deat	th occurred at the travestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) and o, date and pla	d manner as si ace, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	0 0		29c. Licens				igned (Month,	Day, Year)
			* there ?	Hodel			6612		10.5	3.04	
7 1	+ IMA		30. Name and address of person who michael S.	Crauch HO,	tem 23a) (Type,	Print) Brut	C1.7.5	cichar	MD	1081	
	Str	ate	31. Date filed (Month, Day, Year)	32. Segistrar's Sig	nature	parti	-				
	Regist	rar	OCT 25	2004 Beause	15 16	DIE					

State of Maryland / Department of Health and Mental Hygiene 001 35198 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** JEAN GINGRICH HENDRICKS 23 10 04 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2**X** F Months 74 6/9/1930 165-24-7247 Director PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-1 ehow any injury or other traumatic event. It a Michigal Examilier mant be notified at once. 1XYes 2 ☐ No Director DE Frankford Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19945 27 Clover Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No White Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aircraft and Marine Elementary/Secondary (0-12) College (1-4or 5+) 12 Parts Co. Secretary Maryland 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul I. Gingrich ပ Martha Lukens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Brought RT 3 Box 146 Frankford, DE 19945 Baltimore, 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) **Highspire Cemetery** 10/27/04 Highspire, PA 22. Name and Address of Facility Burbage Funeral Home 21. Skumu A Fundal Service Licenses 108 William St. Berlin, MD Juth. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has 1 Yes 2 FINO Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 (No 1 Inpatient Medical Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 L Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) yd ni belli 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 0 Why SIGH 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) DUI /K/_ 31. Date filed (Month, Day, Year) 32. R State OCT 25 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 10 **Physician** 2004 JOHN A. HILL 2359 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL WORCESTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 11-11-1923 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1X M 2□ F Months Days Hours 80 MARYLAND Yrs. Director 218-18-3861 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "neturel", or items 23e or 28e-f show treumatic event, it is Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2√E No DELAWARE SUSSEX OCEAN VIEW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36K MAHOGANY 19970 IIS Funeral 12. Was Decedent Ever in U,S. Armed Forces? 3-25-43 1 M Yes 2 □ No If Yes, Give 3-26-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then "neturel", or iter any Injury or other treumatic event, It a Medical Examp 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: \$ Specify: WHITE 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) AUTOMOTIVE REPAIR SHOP FOREMAN/ AUTO MECHANIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN A. HILL 0 BERTHA THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRETA C. HILL/ WIFE 36K MAHOGANY, OCEAN VIEW, DELAWARE. 19970 20b. Place of Disposition (Name of MELSON SemCAPE OF HEAT OPEN 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ other (Specify) CREMATORY 10-25-04 FRANKFORD, DELAWARE 21. Signature of Funer Sept Livenses 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD. WEST AVENUE, OCEAN VIEW, DELAWARE. 19970 Part. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner sician and buriel-transit or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s efter death. I Director: Af id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54997 10/22/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL DARNELL, MD., 29 BROAD STREET, SUITE201, BERLIN, MARYLAND. 21811 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 6 2004 Registrar

			State of Maryland / Department	artment of Health and Me rtificate of Death	ental Hygier Reg. N	10.2001	25000
	Physicia	9	1. Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Year	3. Impor Zeath
	/Medic		JOSEPH TIMOTHY HANLON		October 1		9:45 a M
). 	Examin	ęr	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		tc. County of Death	
1955	Funeral		12412 Chelton Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bowie If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Yea	rince Geo	place (State or Foreign
L.	Director		579-12-3790 ^{1⊠M 2□F} 80 Yrs.	Months Days Hours Min.	Mar 19, 1	924 Was	hington,DC
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ocation			10d. Inside City Limits
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	r 28a-	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cou	ntry?
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	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1.0.4.2	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White,	
36	rs afte	by Fi	1 Never Married 2 Married 3 Midowed 4 Divorced 1 Never Married 2 Married 1 Never Married 2 No 1943- 1 Yes, Give Year or Dates: 1945	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	ite
9	be filed within 72 hours after death with the Maryland hal Hygiene. od other then "naturel", or Items 23s or 28s-f show event, I'm Me Joal Evarulant must be troitfied at	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/In	idustry
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2	led wi lygien her th	Con	4 Accou			ept. of A	.rmy
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 Is marked other then " Ireumatic event, Italia.	Be	17. Father's Name (First, Middle, Last) John Sullivan Hanlon	18. Mother's Name (rgaret Ga		
Ž	should nd Me mark matic	P		ng Address (Street and Number or Rural			Code)
	alth al		Teresa A. Nyce - daughter 12208	Wynmore Lane, Bow	ie, MD 2	0715	
ore,	es 1 and 2 of Health fitem 27 I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		Location - City or Te	
Ĕ	Pages ment of l		`4 □Donation 5 □Other (Specify) Mt. Ulive	t Cemetery 10/22,		lver Spri	0.
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic once.			2. Name and Address of Facility Gaso 739 Baltimore Ave.,			
	4:		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) Chronic obstruc	tive lung disease			Onset and Death years
	/Medical Examiner		Due to (or as a consequence of):				
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	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
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8760,	cate b	dical	d				
9 xo	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	env
Bo	death atten	iclan	in the past 12 months? Description The past 12 months? 1 Description Live birth 2 Description Fetal death 3 Description 1 Des	Ectopic pregnancy Other (specify)		Month	Day Year
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s, P	w requires that been signed to should be det	ру Р	Part II. Other significant conditions contributing to death but not resulting in the u Parkinson's disease	nderlying cause given in Part I.		o use contribute to t	
ord	law requires as been sign 2 should be	ted	raikinson s disease		1 Tes	2 No 3 No Prot	pably 4 Unknown
Records,	<u>a</u> 88 C	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
	Th ate pag	e Co	25. Was case relerred to medical	OO Diversi Death	1□ Yes 2€ N		2 No
Vital	Physicien: The this certificate haral director, page	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death (6 ☐Other (Specif	(v)
J Of	F F E		27. Manner of Death 28a. Date of Injury 28b. Time of		d. Describe how in		<i>"</i>
sior	Attending F r death. Bctor: After by the funer	atlo	2 Accident investigation	M 1 Yes 2 No			
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Ľ	To the Hospital or within 24 hours after To the Funerel Discompletely filled in	O	29a. Certifier 1 A Certifying Physician: To the best of my knowledge, deat				
	the Ho in 24 h the Fu npletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date a	ind place, and due to	the cause(s)
	To the within 3	M	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month,	Day, Year)
•	. 011	r	- Xmillen Jelle	D01852	Oct	ober 20,	2004
C	E (5) V	9	30. Name and address of person who completed cause of death (Item 23a) (Type,		MD 0070	1/05	
	Sta	te	Paul A. DeVore, MD 4203 Queensbury 31. Date filed (Month, Day, Year) 22. Registrar's Signature	Road, Hyattsville,	MD 20/81	-1435	
	Registi		OCT 2 2 2004 Bearing & from	le			
OF							

			1 - For Stata Registrar	State of Mary	land / Depa <i>Cer</i>	artment of He	ealth and M Death		en2004	35201
			Decedent's Name (First, Middle, Las	t)				2. Date of Death	1	3. Time of Death
	Physicia /Medic		Lewis			Hunsicke	7-	Month October	Day Year 18 2004	11:33 AM
	Examin		4a. Facility Name (If not institution, give		\	4b. City, Town, or L			4c. County of De	ath
			The Johns Hopk			Baltin		ity		
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In IXM 2 ☐ F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov. 28, 1	Year) (ithplace <i>(State or Foreign</i> Country) Insylvania
	Director		193-24-0931 Usual Residence of Decedent	**	72 Yrs.			NOV - 20 5 1	. Joi Ten	IIISylvania
	land ow		10a. State Pennsyl-	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Man a-f st	tor	vania Dauphin	H	arrisbur	g				1XX Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What C	Country?
	23a		3991 Sunnycrest I			17109			J.S.A.	
	ar dek	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TY Yes 2 □ No If Yes, Give Year or Dates: Ko	roon.	1□ Yes 2⊠No	Specify:		Specify: V	Thite
8	2 hou	ed	15. Decedent's Ed	lucation	16a, Deced	dent's Usual Occupat	ion	1	6b. Kind of Busines	s/Industry
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n	uld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show attic event, if a Modical Everuli at mind be rediffed at	Be	17. Father's Name (First, Middle, Last)					e <i>(First, Middl</i> e, M Steinfelt	,	
<u>₹</u>	Men Men Marke Marke	To	George Hunsicker	Sura Delati	10h M-16-					Zin Codo)
Maryland 21215-0036	d 2 st th and 7 Is n traun	n i	19a. Informant's Name/Relationship (7) Patricia Hunsicke:			ng Address (Street ar Sunnverest				vlvania 17109
ပ်	1 an Heal Iem 2		20a. Method of Disposition		0b. Place of Dispo	sition (Name of			Coc Location - City of Harrisbu	
Baltimore,	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Madical Engineer matter rediffied at once.		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		cometery, gran Woodl [emerial	natory or other place awn Gardens	10/2		narrisbu ennsylvan:	
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			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	er the mode of dying,	, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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	ted	Examiner	Sequentially list conditions, if any, leading to immediate couse. End Underly Cause (Disease or injury	10/h:	· 10	1				6 weeks
_6	al-tra	xar	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					(6 COCF C)
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9	tificat ng phy as th	Medi	IS ESTATE							
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			23d. Date of d	elivery Day Year
0	e dea the at ned fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)			TVIOLATI	Day
P.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Phy	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giver	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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200	w require been si should	Completed						24a. Was an	24b. Were	autopsy findings available
Re	The lav	dmo						autopsy	prior to ed? death?	completion of cause of
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Į <	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Other	4 Nursing Ho	ome 5 🗆 Resider	nce 6 Other (Sp	ecify)
n o	ng Pł fter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Work?	?	28d. Describe how	w injury occurred	
sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b		At he may 40		es 2 □No	204 Location (Ct-	and and Mumber of	Quest Dauta Alumbar
Division of Vital Records,	\$ 5. ± 6	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At nome, farm, sti Specify)	reet, factory, office		City or Town,		Rural Route Number,
_	spital ours sours and heral		29a. Certifier 1 Certifying Ph	ysicien: To the best of m	y knowledge, deat	h occurred at the time	e, date and place,	and due to the ca	use(s) and manner	as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated	amination and/or in	vestigation, in my opi	nion, death occur	red at the time, da	ite and place, and di	ue to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier			29c. License		29	d. Date signed (Mo	nth, Day, Year)
			1 de 1	A.N.		RE	5-000	(Stoper 1	8,2004
			30. Name and address of person who				\	7 11		207 000
			Michelle Petron 31. Date filed (Month, Day, Year)	32. Registrar's		Nolfe Str	eet	Baltim	ore WD 3	11284-4100
	Sta Regist		OCT 2 0		.u	Locall E				
				10 - 15V 10 V. V.		> 14 M				

			1 - For State Registrar	Otato of Mi	Ce	rtificate of L	Death	Reg	2004	35202
	Dhusisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month		3. Time of Death
	Physici /Medic		Clara Ja	ne H	looper	,		October	19 2004	9:45 p M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
			Calvert County Nu				Frederic		Calve	rt
	Funeral Director		5. Social Security Number 6. Security Number 11	9X 7. Ag □M 2 ∑]F	ge (In yrs. last birthday) 96 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) Mar 27,	^{9. Bi} 1908 Nor	rthplace (State or Foreign country) Th Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl	ō	MD Calvert			Dringe	Frederic	Ի		1 ☐ Yes 2 No
	28a	rec	10e. Street and Number			10f. Zip Code	TIEGGLIC		g. Citizen of What C	country?
	3a or	Funeral Director	85 Hospital Road				20678		USA	
	death ms 2	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Am	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and Sa or 28e-f show item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Madical Exacting or sail by neilling at	by Fui	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:	ricari, etc.)	Black, Wh	
o	tura stura	ed	15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ation	11	6b. Kind of Business	nite s/Industry
15	n ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or:	(Give	kind of work done of DO NOT use retired	turing most of worki l)	ing		•
212	d within giene. rr than	mo:	10	College (1-40)		cietor of	gas stat	ion :	retail ga	s station
פ	e filed al Hygi other vent, L	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, Ma		
Maryland 21215-0036	should be ind Mental marked o	To E	Milton A.	Lo	max		Minnie	Dora	Leona	rd
lar)	2 shoul and M Is mari		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street a	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
	and 3		Everett C. Lovele	ss, Jr.,	nephew 20	Georgia	nna Lane,	Owings,	Maryland	20736
ore	of Hea of Hea if item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	e)	Date 20	Oc. Location - City of	r Town, State
Ě	Pag ment ant:		`4 ☐Donation 5 ☐ Other (Specify)	Miranda (-2004 H	untingtow	n, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licen	ste		2. Name and Addres		10 D A	Owings,	MD 20736
			23a. Part1. Enter the disease, for comp	ol cations that cause	d the death. Do not ent					Approximate
			Immediate Cause (Final	ne cause on each li	ne.	20				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Card	a consequence of):	hythmic	9			10 minutes
	Examiner				scienchic	Candin	Wescule	on dic	and a	
	15.53	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of).	230,000	V C-G CCIT	or our		
	rtificate be executed ng physician and as the burial-transit	Examine	that initiated events	c						
ó	an ar		resulting in death) Last	Due to (or as	a consequence of):					
68760	ate be nysici he bu	edicai		d						
	ing ph	Med	IF FEMALE:							
Вох	eath cer attendir for use	lan/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
	0 0 0	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∏Pregnant a 9∏Unknown	t time of death 5	Other (specify)				
P.O.	that the dended by the detached		Part II. Other significant conditions or	ontribution to death h	out not resulting in the u	nderlying cause give	en in Part I	23e. Did toba	cco use contribute t	o the cause of death?
ds,	iaw requires that the as been signed by th 2 should be detache	d by	Dementia	_						robably 4 JUnknown
Ö	w requires (been signe should be	Completed						240 1450 00	Oth More o	utanou findinas ausilabla
3ec	9 4 9	Idm						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
a	i cian : The t certificate ha ector, page							1 ☐ Yes 2	No 1 □ Yes	s 2 No
ΖÏ		o Be	25. Was case referred to medical examiner?	Hospital:	0.000	nt 3 DOA Othe	26. Place of Death		2 TO:1- (2	
oţ	Phys r this ral di	\vdash	1 Yes 2 No	1 ☐ Inpatie 28a. Date of Inju (Month, Da		IC 3LI DOA	4 Mursing nor	me 5 L Hesiden 28d. Describe how	ce 6 ⊡Other (Spe	ecity)
on	tending leath. tor: After the funer	tior	1 Natural 5 Pending 2 Accident investigation		y Year) Injury		<br Yes 2 □ No			
Division of Vital Records,	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be determined	200. Flace Ut III)	ury - At home, farm, str c. (Specify)	eet, factory, office	1	28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
Ō	urs after rral Dire	Certification;								
	To the Hospital or At: within 24 hours after of To the Funeral Direct completely filled in by	edical			of my knowledge, deatl f examination and/or in ated.					
	To ti withii To ti comp	Me	29b. Signature and title of certifier	0		29c. License			I. Date signed (Mon	
			eya.	c. su	ana.	D	50653		10-20	-2004
	,		30. Name and address of person who o	completed cause of c	death (Item 23a) (Type,	Print) GY	AM-C.	SUPA	N M	
	6		5851- Dea	le chiv	rollton	Road:	Deale	MD	2075	73

State Registrar

31. Date filed (Month, Day, Year) 0CT 2 1 2004 Steem &

		1	For State Registrar	State of Maryland		rtment of H			giene 00	+ 35203
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last) Marceline Mae			Ab City Town or	Landian of f	2. Date of De Month Octobe	Day Ye	04 1:05 PM
	Examin Funeral Director	eı	4a. Facility Name (If not institution, give s Reeder's Memo 5. Social Security Number 213-64-6463	orial Home	st birthday) Yrs.	Boons If Under 1 Year Months Days	boro If Under 24	Hrs. 8. Date of Bin	Washi	
	D D		Usual Residence of Decedent 10a. State 10b. County MD Washins		Town or Lo					10d. Inside City Limits 11€ Yes 2 □ No
	uth with the 23a or 28e-	Funeral Director	10e. Street and Number 19800 Tranquil			10f. Zip Code 21.7			10g. Citizen of What	
036	within 72 hours after death with the Maryland ane. then "neturel", or Items 23a or 28e-f show he Nedleal Examinational be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ŀ	Was Decedent of Hi fYes, specify Cuba i⊡Yes 2∏xNo		n? (Specify Yes or No Puerto Rican, etc.)	Black, V	American Indian, White, etc. White
21215-0036	within 72 ho ane. then "netur he Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give lite.	dent's Usual Occupa kind of work done o DO NOT use retired nemaker	ation during most o	of working	16b. Kind of Busine	·
Maryland 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) John B. Keilho				Ethe	s Name (First, Middle el Belle	Maiden Surname) Marie J	оу
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23a or 28e-1 show minorient: If item 27 is marked other the "neturel; or Items in a confident on the property injury or other treumatic event, the Madical Examination at the notified at once.		19a. Informant's Name/Relationship (Ty. Beverly Bidle (20a. Method of Disposition 1 Reurial 2 Cremation 3 Revention 4 Dogation 5 Other (Specify) 21. Signsture of Fureral Service Licens	(Daughter) Removal from State Lut	2800 ce of Dispo metery, crer herai	5 01d na sition (Name of matory or other place n Cemete Name and Address Donald F	ery 10	or Rural Route Number al Pike, Date 0/26/04 ompson Fit., Midd	Middlete 20c. Location - City Middlete uneral He	own, MD21769 ovr Town, State own, MD
8760,	cate be executed /Medical Examiner and supplies the burial-transit	ical Examiner	23a Fart 1. Enter the disease, or comb book, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence).	LAR ence of):	er the mode of dyin	g, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of the pregnant at time of decentions	death 3[Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<u>α</u>	requires that t been signed by should be detac	by		NOVON			en in Part I.	23e. Did 1	Δ¢	te to the cause of death?
al Records,	: The law requ cate has been , page 2 shoul	Completed	PARKIN	sons !) 18	EAST		1 Tes	psy prior ormed? deat 200 No 1 □	e autopsy findings available to completion of cause of h? Yes 20 No
ion of Vital	nding Physicien: Th th. :: After this certificate s funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2X No 27. Manuer of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatie 28b. Time o Injury	f 28c. Injur	er: Nurs			Specify)
Division	itel or Attendi urs after death. irel Director: A	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,				City or To	wn, State)	or Rural Route Number,
)	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Alter completely filled in by the funerel	Medical	29a. Certifying Phy (Check only one) 29b. Signature and title of Pertifier	rsician: To the best of my know iner: On the basis of examination and manner stated.	nedge, deal on and/or in	29c. Licens	pinion, death	occurred at the time,	date and place, and 29d. Date signed (M	due to the cause(s)
**	St Regist	ate	31. Date filed (Month, Day, Year)	ah 382 S. C. 32. Registrats Signat	level		., Ha	gerstown		

		•	1 - For 10-29-04 State Amend#	'ടിവം	State of M	Marylan er Infor	id / Depa	artment <i>rtificate</i>	of He	ealth a	and M	lental Hy	giene (004	35204
\$	gt		Decedent's Name (First,			CLITCH	mar cocr				1	2. Date of De	ath	V	3. Time of Death
	Physicia /Medic		J	dn R.	Jones							October	20, 20	O4_Year	11:00 A.M
	Examin		4a. Facility Name (If not ins					4b. City, T						unty of Dea	
			Fort Washingt 5. Social Security Number	on Hos			last birthday)	If Under 1		Wash If Under		n 8. Date of Bir			eorge's
	Funeral Director		579–38–8385		M 2□F	7			Days	Hours	Min.	(Month, Da	y, Year)	7 No	thplace (State or Foreign cuntry) rth Carolina
	D		Usual Residence of Decede									Terren	y 0,172	./ 1101	iui Carotti ii
	arylar ehow	-	10a. State 10b. C	-	orge's	10c. Cit	y. Town or Lo		not Til	ochim	tan				10d. Inside City Limits 1127₹es 2 ☐ No
	he Mi	ecto	Maryland Pri	ite Ge	orge s					ashing	guar		10- Citi	-4 What C	
	with the or 3	Dir	7606 Hartal					10f. Zip (Code	2074	4		10g. Citizen	.S.A.	ountry?
	ms 23	Funeral Director	Klovsta 11. Marital Status	d	12. Was Decede	nt Ever in U	.S. 13.	Was Decede	nt of His	panic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	- 14.		erican Indian,
9	or Itams	Fur	1 Never Married 2	Married	Armed Force 1XXYes 2 [If Yes, Give	is? ⊒ No	1	if Yes, specif 1 ☐ Yes 2 l		, Mexicar Specify:	n, Puerto	Hican, etc.)		Black, Whit ecify: B	
003	72 hours after death with the Maryland Inaturel', or Itams 23s or 28s-f ehow dissi Evariliset matte rediffed at	d by	3 Widowed 4 Div		Year or Date	s:									
21215-0036		Completed	(Specify only		ade completed)		(Give	dent's Usual kind of work DO NOT use	done du	<i>urina</i> mos	t of worki	ng	16b. Kind	of Business	/Industry
12	iene.	dwo	Elementary/Secondary (0 12th grade)-12)	College (1-4d	or 5+)		g Cans	, ,				D.C.	Cover	ment
פָּ	e filed within al Hygiene. I other then ' vent, I're Ma	BeC	17. Father's Name (First, M	liddle, Last)		1 210	g wil		18. Mothe	er's Name	(First, Middle,			1124.30
/lar	2 should be and Mental Is markad or raumatic eve	To E	Jdh	n Jone	S							Bessie B	ell		
Maryland	2 sho and Is ma rauma		19a. Informant's Name/Rel Mrs. Sandra E.		, ,							l Route Numbe			
	1 and Health em 27 ther t		20a. Method of Disposition	JUES	(WITE)	20b. F	Place of Dispo	OVS sition (Name	ad e of	VE TOL	.c was	hington,	20c. Locati	ion - City or	Town, State
nor	ages ant of t: If it y or o		1 ☐ Burial 2 ☐ Crem `4 ☐ Donation 5 ☐ Ot	ation 3	Removal from Sta	te Che	sametery, cirer sapeake	natory or oth Crenatc	ner place	Inc.	10/ 27	404		-	Aryland
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic e anges.		21. Signature of Funeral So			/	22	2. Name and	Address		2)	LLINS FU	NERAL H	OME, IN	C.
ä	Department Department Important ir any ir gange		Junet	C	- male	138						bshingta		_	
			23a. Port1. Enter the disease shock, or heart failure	se, or com	plications that cause one cause on each	sed the deat i line.	h. Do not ent	er the mode	of dying	, such as	cardiac c	r respiratory a	rrest,		Approximate Interval Between
	Physician-		Impediate Cause (Final diffease or condition	0.00	a.AcuTe	Ce	vebr	o Va	SKY	lak	A	ecid	eni		Onset and Death
	/Medical Examiner		resulting in death)	_ (Due to (or	as a conseq	uence of):								
		er	Sequentially list conditions if any, leading to immediate		b. Due to (or	as a conseq	uence of):								Water transfer
	uted	Examine	Sequentially list conditions if any, leading to immediate Cause (Disease or injury that initiated events	1	с										
oʻ	e exectan an an urial-tr		resulting in death) Last			as a conseq	uence of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical			d					-					
9	leath certific attending pl	/Mec	IF FEMALE:		23c. If yes, outcor	ne of pream	ancy							0-1	P
Вох	atten for us	cian	23b. Was decedent pregna in the past 12 months		1 ☐ Live birth	2 Feta	Ideath 3	Ectopic pre					230.	Date of de Month	Day Year
P.O.	that the de ed by the detached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unknowr										
		by P	Part II. Other significant co	onditions (contributing to deat	n but not res	ulting in the u	nderlying cau	use givei	n in Part I		23e. Did to	obacco use	contribute to	the cause of death?
ord	law requires as been sign 2 should be	ted t	Conges	TIVA	e He	7-5	<u> </u>	11.4	Re			10	Yes 2□N	o 3∏Pr	robably 4 🖭 Unknown
Vital Records,	e law r has be ge 2 sh	Completed	Acute	Re	Jan	FZ	ilur	9				24a. Was autop	osy	prior to	utopsy findings available completion of cause of
E	Th ate pag	Con	ARTERIO SC	ler	oTic C	ard	10 V 2	scul	2~	DIS	e 2 S		rmed? 2 No	death?	5≹_ No
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to mexaminer?	redical	Hospital:		IEDIO		Othor			(Check only o			
o		H- 1	1 ☐ Yes 2 ☐ No 27. Manner of Death		28a. Date of li (Month,		ER/Outpatier 28b. Time of		c. Injury	at Nu	-	me 5 🗌 Resid 28d. Describe h			cify)
ion	Attending Ph ir death. ector: After th by the funeral	atio		Pending nvestigatio		Day Year)	Injury	М	Work? 1 □ Y	? es 2 🔲:	No				
Division of	l or Atten after deat Director:	Certification;		Could not b determined	286. Place of	Injury - At he	ome, farm, str	eet, factory,	office	-	1	28f. Location (S City or Tox	Street and No	umber or Ru	ural Route Number,
	ital or Aurs after rel Dire														
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical			nysician: To the be miner: On the basis and manner	s of examina									
	To th To th	Ž	29b. Signature and title of	certifier			-	29c.	License		6 0			-	h, Day, Year)
1	6		1 150	1. 1	6.			14) (98	0 7		001.	-21-	04
K	- 18)		30. Name and address of p	erson who	1	of death (Iten	n 23a) (Type,	•	-1			A	C >	7 ~	20037
	Sta	ite	31. Date filed (Month, Day,			strar's Signa	ture ature	70	414	eal	V	Ave.	34 -	س د	20032
	Registr		OCT 2 2	2 2004	Block	K	has	16.1							

State of Maryland / Department of Health and Mental Hygien 2004 35205 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** MOMMON MARY 00 11.30. 1 LOOH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEOMOS RD #515 B UNKERHILL AlH a BRENTWOO If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 1928 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2X F 579-64-3387 Director 75 December Georgia Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits 28e-f show other treumatic event, the Medical Exercitive trust be notified at Yes 2 No Completed by Funeral Director Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20722 Items 23g 4142 Bunkerhill Road U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: Black 3 ☐ Widowed 4 ☑ Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private 10th Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental P William Tillman Johnson Matilda Stykes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Irma Johnson/Sister 7 Barberry Court Upper Marlboro, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State jo <u>H</u> 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Brentwood, Maryland 4 □Donation 5 □Other (Specify) FT Lincoln Cemetery 10-30-04 21. Signature of neral Solice Linnsee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician A BDONINAL RUPTURG-HNEUSNYSH HORTIC resulting in death) /Medical Due to (or as a consequence of): **Examiner** HYPGRIGHED N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 **2** No 1 ☐ Yes Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) þ 4 \ Homicide filled in 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 PMS1 Llon D 40395 10/21/04. Salls 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sara Ramachadran M.D. 1221 Mercantile Lane Largo, Maryland 31. Date filed (Month, Day, Year) 2. Registrar's Signature 2 2 2004 Registrar

			1- State of Mar State of Mar Registrar		artment of Health ar tificate of Death		eng 004	35206
	00		Decedent's Name (First, Middle, Last)			2. Date of Death Month	n Day Year	3. Time of Death
	Physicia /Medic		Charles R	Κε	ıshuba	Oct o	20 2	0741 M
	Examin Funeral		4a. Facility Name (If not institution, give street and number) Peninsula Legional Nedical 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	4b. City, Town, or Location of I	Hrs. 8. Date of Birth	4c. County of Death	
Н	Director		157M 2015	91 Yrs.	Months Days Hours	Min. (Month, Day, Aug 13,		nsylvania
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				
	shov	5						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	28a-f	Director	MD Wicomico	Quanti	. C O	10	og. Citizen of What Co	
	with sor	١					USA	unitry:
	ns 23	Funeral	6442 Main Street 11. Marital Status 12. Was Decedent Ev	ver in U.S. 13. V	21856 Was Decedent of Hispanic Origin	n? (Specify Yes or No-	14. Race - Amer	
21215-0036	s within 72 hours after death with the Maryland Jiene. r then "naturel", or Items 23a or 28a-f show The Medical Evairing from the Leadilled at	þ	A med Forces? 1 Never Married 2 Married 1 Married 1 Married 2 No 1 Married 3 Married 2 No 1 Married 1 Mar	1	f Yes, specify Cuban, Mexican, I I ☐ Yes 2፟፟፟ No Specify:	Puerto Rican, etc.)	Specify: W	_{o, etc.} hite
5-0	72 hc natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupation kind of work done during most o DO NOT use retired)	of working	6b. Kind of Business/l	ndustry
121	within ene. then "	mpi	Elementary/Secondary (0-12) College (1-4or 5+))				
2	a filed v il Hygie other t vent, in		17. Father's Name (First, Middle, Last)	Mech		s Name (First, Middle, M	Automotive	Unknown
an	4 5 5 P	To Be	Unknown	Kashub		, , , , , , , , , , , , , , , , , , , ,	,	Olliciio Wil
Maryland	2 should by and Menta is marked aumatic en	ř.	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number	or Rural Route Number,	City or Town, State, Z	ip Code)
	교육 2 후		William Matiskella- Nephew	957 C	hase Road Shar	vertown, Per	nnsvlvania	18708
J.	of Head		20a. Method of Disposition	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place)		20c. Location - City or 1	
Ē	Pages nent of l ant: If its ury or o	3	1 Burial 2 □ Cremation 3 □ Removal from State Gradient Signature (Specify)	Memorial	· ·) - 25-2004	Carvertown,	PA
Baltimore,	permit. Pag Department Importent: t eny injury o		21. Signature of European Service Licensee		Name and Address of Facility O5 E Main Stree		neral Home ry, MD 2180	04
			23a. Pagy. Enter the disease, or complications that caused a shock, or heart failure. List only one cause on each time	e death. Do not ente	er the mode of dying, such as ca	ardiac or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	amond	>			Onset and Death 3 - 3 QC - 3
	/Medical Examiner		resulting in death) Due to (or as a	consequence of):				3.5
	LAGIIIIIEI	_	Sequentially list conditions, b. Due to for one	consequence of):				
	ted	nine	cause. Enter Underlying Cause (Disease or injury	consequence or).				
_6	icate be executed physician and s the burial-transit	Examiner	that initiated events c.	consequence of):				
68760,	e be e siciar e buri	edical E	d					
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.O. Box	law requires that the death certifics as been signed by the attending pt 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delin Month	very Day Year
Ω.	s that ned b e deta	by Pł	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Vital Records,	w requires been sign should be		Sande danst	>		1 □ Ye	s 2□No 3□Pro	obably 4 Dunknown
006	aw re	Completed				24a. Was an	24b. Were au	topsy findings available ompletion of cause of
Ä	0 4 0	mo				perform	ed? death?	2□ No
Ita	ilcien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	32-27	26. Place o	f Death (Check only one		
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient			ing Home 5 Resider		ify)
	ding P. h. After t funera	i.	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	Work?	28d. Describe how	w injury occurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	A home 6	M 1 Yes 2 No		eet and Number or Ru	m l Davida Musebas
Division	= = = =	Certification:	4 Homicide determined 256. Place of Injury building, etc.	y - At home, farm, stre (Specify)	еет, тастогу, оптсе	City or Town,		rai nobie ivurnoer,
_	To the Hospitel c within 24 hours af To the Funerel D completely filled in	edicai Ce	29a. Certifier 1 Certifying Physician: To the best of (Check only 2 Medical Examiner: On the basis of e	examination and/or inv				
	To the within 2. To the complet	Med	one) and manner state 29b. Signature and title of certifie	ru.	29c. License number	29	d. Date signed (Month	(,(Day, Year)
	N N N N N N N N N N N N N N N N N N N		La Val		1) 15	7.57	10/201	00
,			30. Name and address of person who completed cause of dea	ath (Item 23a) (Type.	Print)		10100	7
Q			Jour Simston they O	com C.	of any	1842		/
	Sta		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	1			
	Registi	rar	OCT 2 1 2004 Sen	wa &	Sparks			

DHMH 17 Rev 1/2001

Charles Kashuba

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. NZ 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nikolai Kasak 4:55 PM 10 zz2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton 1581 Fallowfield Court Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (St. Months | Days | Hours | Min. | Sept. 11, 1916 | Estonia 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 88 061-28-6583 Yrs. Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28e-1 show 10c. City, Town or Location 10h Counts 10d. Inside City Limits 10a State 27 is marked other than "natural", or items 23a or 28e-1 show traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Maryland Anne Arundel Crofton Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1581 Fallowfield Court 21114 USA Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married $_{\mathit{Specify}:}$ White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Building Contractor Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f Mental h permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked any ligitry or other traumatic events. Unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oaike Kasak (wife) 1581 Fallowfield Ct. Crofton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crematory10/23/2004 Alexandria, Virginia 22. Name and Address of Facility Beall Funeral Home 21_Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, Maryland 20715 Approximate Interval Between Onset and Death 3 Mor/hs 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In strong one cause on each line. Immediate Cause (Final Cerebrovascular Accident **Physician** disease or condition resulting in death) /Medical Examiner Trusion Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day Month Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. the 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Fibrillation 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 21**X** No 1 ☐ Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home Hesidence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1/2/Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and D 50343 October 23, 2004 ess of person who completed cause of death (Item 23a) (Type, Print) Center Drive #201, Bome, MD 20716 Health 14999 Had 31. Date filed (Month, Day, Year) State 2 5 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 35208 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 19:15 P Ronald Darrell Krause, Sr. October 19. 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 04/10/1935 Birthplace (State or Foreign Country) 5. Social Security Number Sex 1/FIM 2□ F **Funeral** Months 69 Maryland 217-28-2486 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location works r than "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Tyes 2 No Allegany Cumber land Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21502 USA 13603 Yuma Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify: ۵ White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Laborer Tire and Rubber permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Importent: If item 27 is marked other I any injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Krause Melinger Frank Marguerite Felicia ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13603 Yuma Street, Cumberland, MD Ronald D. Krause, Jr. / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 10/20/2004 Cumberland, MD * 4 ☐ Donation _5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 desous elect 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) about 6 mos. Physician Metastatic Carcinoma Lung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, ed bluods 1 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 🗗 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ↑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2 ☑ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 5 Pending investigation 1 🖄 Natural 1 ☐ Yes 2 ☐ No М death. n 24 hours after death.

Be Funerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26907 October 20, 2004 4/1 Hidh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit S. Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)
OCT 2 1 2004

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

racks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 200 L For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** OCTOBER EULA R. LEONARD 15, 2004 1:55P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILLENIUM HEALTH AND REHAB CENTER PRINCE GEORGES FORT WASHINGTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Funeral Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months. 1 M 2000 Director 70 05, 1934 NORTH CAROLINA 244 52 8814 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State iral, or items 23a or 28a-f ehow Examiner must be notified at XXYes 2 No Director MARYLAND PRINCE GEORGES CLINTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code UNTIED STATES 8600 MIKE SHAPIRO DRIVE 20735 Completed by Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK If Yes, Give Year or Dates: 3 ☐ Widowed XX Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 10TH HOUSEKEEPER PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JAMES EDWARD GRANT LUCY PEARL BATTLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is n any injury or other traun 2006. GALE CARROLL-DAVIS / FRIEND 304 CORLA DRIVE OXON HILL, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) LINCOLN MEMORIAL CEM. 10/22/2004 SUITLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND.INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Part1. In er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate duse (Final disease or condition resulting in death) **Physician** BRAIN CANCER /Medical Due to (or as a consequence of) Examiner BREAST CANCER WITH METASTASIS TO BRAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes XX No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy this certificate 2**X X**Vo 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXNo P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred Certification: or Attending 1XXVatural 5 Pending 2 🗌 No investigation after death 2 Accident 3 🗋 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0037060 **AUGUST 22, 2004**

Registrar DHMH 17 Rev 1/2001 Registrar's Signature

6188 OXON HILL RD. #701

OXON HILL, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UCHECHI OPAIGBEOGU, M.D.

OCT 2 2 2004

31. Date filed (Month, Day, Year)

State

			State of Maryland 1 - State Amend Item 10a per FH, G837, 1	Department of Health and Me 1.1.05,04dhb Certificate of Death	ntal Hygien (004 35210
	Physici	an	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day	3. Time of Death
	/Medic		Isabel Martinez Milingwor		c to peris 2	2004 17:10 IM
f.	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death	4¢. Coi	unty of Death
	Eugevel		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs. 78	Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		None 1□M 2xF 57	Yrs. Months Days Hours Min.	(Month, Day, Year) ulv 5. 1947	Guayaquil, Ecuado
	p ,		Usual Residence of Decedent			-
	laryla shov	'n		own or Location		10d. Inside City Limits 1 → Yes 2 □ No
	the M	Director	Ecuador Guayao	10f. Zip Code	10g Citizon	of What Country?
	with 3a or	Ö				_
	death ms 2;	Funeral	Avenue Second 509 Los Ceibos 11. Marital Status 12. Was Decedent Ever in U.S.	None 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric		Race - American Indian,
ထွ	after or ite	Fur	1 Never Married 2 Married 1 Yes, Give	7777		Black, White, etc.
21215-0036	within 72 hours after death with the Maryland jiene. r than "natural", or ttems 23a or 28e-f show the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	2000		ecify: White
15	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind o	of Business/Industry
12	within iene. than "	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	Oran	1 Ноте
	Hyg Hyg it,	0	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Sun	
Maryland	chould be id Mental marked o	To B	Leon Martinez	Isabel Y	llingworth	
lary	2 should and Men is marke eumetic			9b. Mailing Address (Street and Number or Rural R		
	and and m 27			Avenue Second #509 Los O		• -
Baltimore,	Pages 1 nent of He int: If itar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of Date of etery, crematory or other place)		on - City or Town, State
Ë	t. Partmen					ood, Maryland
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumetic enonge.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hines 11800 New Hampshire		
			23a Part1. Enter the disease, or complications that caused the death. E shock, of heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Pulmonary	edená		Onset and Death
	/Medical Examiner		Due to (or as a consequence			3 10
	ZXGIIIIICI	_	Sequentially list conditions, if any leading to immediate Due to for as a consequent			3 months
	ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury	GG GI).		
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		•	10 E			
Вох	eath certifi attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetel de:	ath 3□Ectopic pregnancy	23d.	Date of delivery
_	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be delached for use a	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown			Month Day Year
P.O.	ires that the de signed by the a f be detached f		Part II. Dther significent conditions contributing to death but not resultin	g in the underlying cause given in Part I	23e Did tohacco use c	contribute to the cause of death?
ds,	signe d be d	d by	Breast adenocarcinoma	g in the differning cause given in Fatti.		o 3 Probably 4 Unknown
200	w require been si should I	ete	310		24a. Was an 24	th Ware autopey findings available
Rec	The lavate has page 2	Completed			autopsy performed2	b. Were autopsy findings available prior to completion of cause of death?
tal	ician: Th certificate ector, pag	ပိ	25. Was case referred to medical	26. Place of Death (C	1 Yes 2 No	1 ☐ Yes 2 No
<u>></u>	ysician: is certific director,	To B	examiner? Hospital:	Other	5 ☐ Residence 6 ☐	Other (Specify)
0	ng Ph ter th neral			b. Time of 28c. Injury at 28d Injury Work?	. Describe how injury oc	curred
sio	andir eath. or: Al	catic	2 Accident investigation	M 1 Yes 2 No		
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office 28f.	Location (Street and Nu City or Town, State)	ımber or Rural Route Number,
_	spital ours a narel I		29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death occurred at the time, date and place, and	due to the cause(s) and	manner as stated
	To the Hospital or Attanding Phys within 24 hours after death. To tha Funarel Diractor: After this completely filled in by the funeral di	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination and manner stated.			
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number		gned (Month, Day, Year)
	1		- Court	RES-000	Octob	ber 18,2004
	6		30. Name and address of person who completed cause of death (Item 23.	a) (Type, Print) Johns Hopkins C	neology Cer	nter
			30. Name and address of person who completed cause or death (Item 23. Hethy Carraway 401 North Broad 31. Date filed (Month, Day, Year) 32. Registrar's Signature	edway Baltimore Mar	yland 21:	231
	Sta Registr		OCT 20 2004 Deces	9 hours		
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State of Maryland / Department of Health and Mental Hygien 2004 35211 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20, 2004 12:45 AM Edna B. Moffitt CHOBEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV 4, 1906 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 12 E 97 145-32-6778 Director Pennsylvania Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, it is Marked Examinar must be notified #1 1 Types 2 □ No Director Maryland Prince George's Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9510 Wellington Street 20706 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 2 should be filled within 72 hours after deal and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Specify White 1 Yes 2 X No Specify δ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Teacher Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Florence M. Smith Harry O. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau 9510 Wellington Street, Lanham MD 20706 David L. Moffitt/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Union Cemetery 10/25/2004 Ramsey, NJ 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service Licensee 9013 Annapolis Road, Lanham MD 20706 23a. Part | Enter the disease, or comunications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final 02000 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the buriat-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? s certificate has be lirector, page 2 s 2□ No 1 Tyes 1 Yes 2 ₩ 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Umpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D25079 10/20/0 contra piece 002 Len en no 2070 6 30. Name and address of person who completed cau of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiena 35212 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 12:50a LaMarr T. Mosby October 0 20,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🖾 F 84 October 6,1920 Director Washington, D.C 577**-**22-8248 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-1 show the Medical Examinar must be notified at 1 XYes 2 No Director Maryland Prince Georges Adelphi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 239 Apt. 227 20783 1836 Metzerott RD. United States Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Black Specify 3√ Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If ten 27 is marked other then "ne any injury or other treumatic event and once." Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Therapist Federal Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arizonia Fraction George Addison 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5639 Prescott Ct. Capitol Heights, Md. 20743 Patricia Massey / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.24,2004 Washington, D.C. Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Alexander S. Pope Funeral Homes, P.A. 5538 Marlboro Pike/Forestville, Md. 23a. Pent T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a **Examiner** Sequentially list conditions, Due to for as a Examiner fany, toacing to inmodificause. Enter Underlying Cause (Disease or injury taw requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No page 2 No 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1X Inpatient 2 ER/Outpatient 3□ DOA 2 1 Yes this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: Hospital or Attanding 5 Pending investigation 1 X Natural 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NASREE CARROLL ANGO 7610 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [35213 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:25 P October 0 21, 2004 91119 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If hot institution, give street and number) Examiner 1950 Crossing Stone Court Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 7, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 93 Months 1 ☐ M 2 📆 F 313-09-8795 1910 Yrs. Missouri Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location - wove item 27 is marked other than "natural", or itama 23a or 28a-f shov other traumatic event, the Modical Examination with be notified #1 1 X Yes 2 □ No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 USA 1950 Crossing Stone Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Oil Corp. Executive Secretary 12 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be **Hoffman** Adleen William W. Cocks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1950 Crossing Stone Court, Frederick, MD 21702 Lucy King/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition artment of h ortant: If its njury or of 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 10/25/2004 Frederick,MD Frederick Crematory 22. Name and Address of Facility Stauffer Funeral Home, PA permit. Departn 21. Signature of Funeral Service Licensee mpon any is 1621 Opossumtown Pike, Frederick, MD 21702 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days **Physician** neumonio /Medical Due to (or as a consequence of): bstructive Pulmonary Disease Examiner hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown þ 23a. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 No 3 Probably 4 Unknown has been sig se 2 should b Completed Vascular 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 1 No certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 1 ☐ Yes 21 No this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funaral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide Hospital

State Registrar

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29a. Certifiei (Check only one)

29b. Signature and title of certifier

Stefanacci Richard DO. 6. 31. Date filed (Month, Day, Year 32. Registrar's Signature 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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The State The County The County The State T	Examine Funeral	r	4a. Facility Name (If not institution, given for the Lee of Social Security Namber 6. state of the social Security Namber 6. state of t	Warsing 7. Age (If you	Home s. last birthday)	Boo If Under 1 Year	ns boro	8. Date of Birt (Month, Pe) March	Washi	ng ton
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Physician /// Medical Examiner Physician // Medical Examiner /	Pages 1 at nent of Hea nt: # Hem nry or othe		20a. Method of Disposition 1 √ Burial 2 ☐ Cremation 3	20b	ort Line	coln Ceme	tery		Brentwood	, Maryland
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	Hospital or Attending 4 hours after death. Funeral Director: Afte sely filled in by the fune	0	29a. Certifier (Check only 2 Medical Exi	miner: On the basis of exam						

State of Maryland / Department of Health and Mental Hygiene []

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r	3. Time of Death
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	Funeral		Anne Arundel Me 5. Social Security Number 6. Sex	7. Age (In yrs. last t	birthday)		nnapoli If Under 24 Hrs	8. Date of Bi	rth	9. Birthp	place (State or Foreign
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215-0036	be filed within 72 hours after death with the Marylan hal Hygliene of the matural; or itema 23a or 28a-f show of other than "natural; or itema 23a or 28a-f shown; the Madical Examiner mant be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation 16 completed)	(Give k	nt's Usual Occup ind of work done	durina most of wo	orking	16b. Kind of	Business/In	dustry
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Maryland	C1 00 -00 00		19a. Informant's Name/Relationship (Typ			Address (Street					
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100			23a. Pater. Enter the disease, or complice mock, or heart failure. List only on	ations that caused the death. De cause on each line.	o not ente	r the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
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B	The law requires that the death c tte has been signed by the attenc bage 2 should be detached for us	by Physician	in the past 12 months?	4☐Pregnant at time of death 9☐Unknown		Other (specify)			.•	101111	bay roan
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ita	Phyaician: r this certifica ral director, i	Be	25. Was case referred to medical				26. Place of De	ath (Check only	one)		
>	Physic this ce al direc	Tof	examiner? 1 ☐ Yes 2 No	ospital: 1⊠ Inpatient 2 ☐ ER/	Outpatient	3□ DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Res	idence 6 🗆 O	ther (Specif	у)
0	ding Ph h. After th funeral	:i	27. Manner of Death	28a. Date of Injury (Month, Day Year)	. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occu	ırred	
ō	ath. er: Af	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,	, , ,		Yes 2 □ No				
Division of Vital Records,	l or Attence after death Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office			(Street and Nun own, State)	nber or Rura	al Route Number,
Ö	tal or	Certification:		, , , , , , , , , , , , , , , , , , , ,							
	To the Hospital or Atlending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	cal	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knowled ter: On the basis of examination	ige, death	occurred at the tir	me, date and place	e, and due to the	cause(s) and r	nanner as s	tated.
	the H in 24 the F	Medical	one)	and manner stated.							
	To To	~	29b. Signature and title of certifier	0 . 10 .		29c. Licens	e number		29d. Date sign		
,			Surame	Knallan!	00	H4:	2733	>	octor	200	19,2004
			30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type, F	Print)				10.	
			Suzana Rind	eleisik 20	1 10	Medieul	Pho	4 Bos	e civilis	12	0
	Sta		31. Date filed (Month, Day, Year) OCT 2 0 21	32. Paistrar's Signature)	1		
	Regist	rar	UC 1 4 U Z	104 Marine 1	· A	melle					

			For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artment of I rtificate of	Health and Death	Mental Hy	giene Reg. No.	2004	35216
T			Decedent's Name (First, Middle	e, Last)		-			2, Date of Dea	ath		3. Time of Death
	Physicia		IDA J. P	USEY					Month 10	24	2004	8:20a ^M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and n	u <i>mber)</i>		4b. City, Town,	or Location of Dea	th	4c. (County of Deat	h
			Genesis Elder	Care			Salisb			Wi	LCOMICO	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 1 F	7. Age (In yrs. last birthday	If Under 1 Year Months Days			h Y. Ygar	9. Birt	hplace (State or Foreign untry) y Land
	Director		213-10-3435	I W ME F		90 Yrs.			12/2//	1913	Mar	ytand
	and **	1	Usual Residence of Decedent 10a. State 10b. County		1	Oc. City, Town or L	ocation					10d. Inside City Limits
	Maryl 1 shc	ō	MD Wicom	ico		Salisbury	,					1 AYes 2 □ No
	28a	Director	10e. Street and Number	100		Dairbuary	10f. Zip Code			10g. Citîz	en of What Co	untry?
	3a or		200 Civic Avenu	e			21801				USA	
	death ms 2	Funerai	11. Marital Status	12. Was De	cedent Ev	er in U.S. 13.	Was Decedent of	Hispanic Origin? (S	Specify Yes or No	- 1	4. Race - Ame	
٥	2 should be filed within 72 hours after death with the Maryland and Meniat Hygiene. Is marked other than "natural", or Items 23a or 28a-f show eumatic event. It a Medical Examine must be notified at		1 ZNever Married 2 ☐ Mar	ried 1 ☐ Yes	2 No		1 ☐ Yes 2 ☐ No	san, Mexican, Puer Specify:	to Hican, etc.)		Black, White	
ဋ	ours iral,	d b	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:		10 163 20 100	орвену.			Specify: wh	ite
7	72 h natu	Completed by	15. Deceder (Specify only highe	nt's Education est grade completed	1)	16a. Dece	edent's Usual Occu e kind of work done	pation during most of wo ed)	rking	16b. Kin	nd of Business/	Industry
12	withir than	g.	Elementary/Secondary (0-12)	College	(1-4or 5+)		l Design			Flo	orist	
2	Hygir Hygir ther		17. Father's Name (First, Middle,	Last)		1 1010	<u> </u>	1	me (First, Mîddle,			
Maryland 21215-0036	ould be i Mental l arked o	To'Be	Ernest R. Puse	V				Laura	Butle	r		
аZ	should and Men marke umatic		19a. Informant's Name/Relations	_		19b. Mai	ing Address (Stree	t and Number or R	ural Route Numbe	er, City or	Town, State, Z	Tip Code)
	is 1 and 2 should of Health and Meritem 27 Is marke other treumatic		Betty Hitch (niece)		208	Coulbour	ne Lane,	Snow Hi	11, M	1D 2186	3
Š.	of He of He litem	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Domoval from	m Ctata	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Loc	cation - City or	Town, State
Ĕ	Pages nent of I ant: If its ury or o		`4 □ Donation 5 □ Other (5		II State	Portersvi	lle Ceme	tery 10/2	26/2004	Stoo	ckton, 1	MD
Baltimore,	permit, Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service	Licensee	0	Í	2. Name and Addr Iolloway	Melson Fracility Nelson Franciscon Franciscon	uneral Ho	ome,	P.A.	1851
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused th	ne death. Do not er						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(2)	IAD		AUCER					Onset and Death
	/Medical		resulting in death)	Due to	o (or as a	consequence of):		•				
	Examiner		Sequentially list conditions,	b								
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Z Duck	o (or as a c	consequence of):						
	xecut and II-trar	xan	that initiated events resulting in death) Last	c	o (or as a	consequence of);						
8760,	cate be executed physician and the burial-transit	dicai									T.	
687				V								
ŏ	n cert anding use a	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o			□Ectopic pregnanc	24		2	3d. Date of deli	
P.O. Box	Attending Physician: The law requires that the death certific relath. sctor: After this certificate has been signed by the attending by the tuneral director, page 2 should be detached for use as	by Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		gnant at tir		Other (specify)	-,			Month	Day Year
	that hed by deta	y Ph	Part II. Other significant conditi	ons contributing to	death but	not resulting in the	underlying cause g	ven in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?
Sp	quires n sign uld be		- ASC	UD					1 🗆 1	∕es 2□	No 3□Pr	obably 4 Unknown
000	aw requir s been si 2 should	Completed	- DV;						24a. Was		24b. Were au	topsy findings available
B	The la	E O							autop perfo 1 Tes	rmed?	death?	completion of cause of 202 No
ita	rtifica	Bec	25. Was case referred to medica	ıl				26. Place of De	ath (Check only o			
<u>~</u>	hysic nis ce I dire	To	examiner? 1 □ Yes 2 □ No			2 ER/Outpatie	INT 3 DOA		Home 6 Resid	dence 6	☐Other (Spec	cify)
0	ng Pl		27. Manner of Death ☑ Natural 5 ☐ Pendi	1840	e of Injury onth, Day	Year) 28b. Time Injury	W		28d. Describe h	now injury	occurred	
Sio	tendi leath. tor: A the fu	cati	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	not be	4 I - i]Yes 2 □No	204 Location //	Ctrant and	t blombar or Do	ral Route Number,
Division of Vital Records,	or At after of Direction by	Certification:	4 Homicide deterr		ding, etc.	/ - At home, farm, s (Specify)	treet, factory, office		City or Tov			rai noute ivumber,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2			ng Physician: To t								
	he Ho in 24 t ine Fu ipletely	Medical	one)		basis of e			·				
	To To	Σ	29b. Signature and title of certific	MAIDA	3 A	MAH		3 2 0 1 4		29d. Date	signed (Month	n, Day, Year)
			- ruam	JV LY 4	Uso of da-	th (Itam 225) /T				10/22	209	
71	H. 1			10000VA	- / 6	oth (Item 23a) (Type of MI'I A- s Signature	ovd st	- 504	B 50/1	3 BU	ry an	0 4804
	Sta Registi		31. Date filed (Month, Day, Year OCT 2	5 2004 32	Registrar'	s Signature	barde				,	

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

			For State Registrar	Sta	ate of I	Marylar	nd / Depa		t of H	ealth a	and M		gien	200	L	352	15
			Decedent's Name (First, Middle	a, Last)								2. Date of De	ath			3. Time of Dea	ith .
	Physici		Eloyd	Ross								Month Octob		ay Ye 20	04	1:25 P	М
	/Medic Examin		4a. Facility Name (If not institution	, give street	and numb	er)		4b. Cily,	Town, or	Location	of Death		4	c. County of D		1,00	
			Washington Adv	entist	Hosp	ital		Tal	coma	Park			M	ontgom	erv		
	Funeral		5. Social Security Number	6. Sex		Age (In yrs.	last birthday)	If Under Months		If Under Hours		8. Date of Bi (Month, Da	rth			ace (State or Fo	reign
	Director		249-28-0780	1 🔀 M 2		81	Yrs.	INIGITATIO	Days	110013		Februa			uth	"Caroli	na
	D ≥		Usuel Residence of Decedent 10a, State 10b, County			10c C	ity. Town or Lo	cation							10	Od. Inside City Li	mite
	sho	5		- 0				Cation							"	1 £7 Yes 2 [
	28a-f	ect	MD Princ 10e. Street and Number	e Geor	ge s	A	delphi	10f. Zip	Codo				10- 0	itizen of What	0-11-		
	with	ä	8112 19th Pla	CO					0783				_	S.A.	Couri	ity r	
	ns 23	by Funeral Director	11. Marital Status		as Decede	ent Ever in U	J.S. 13.			spanic Ori	gin? (Spe	cify Yes or No		14. Race - A	merica	n Indian	
10	rher	표	1 ☐ Never Married 2 ☐ Mar	ied 1 [med Force ⊠Yes 2	s?	1			n, Mexicar	, Puerto I	cify Yes or No Rican, etc.)		Black, W			
ř	all, o	ρ	3 ☑ Widowed 4 ☐ Divorced	If Y	Yes, Give ear or Date	is:		1 ☐ Yes	2⊠ No	Specity:				Specify:	31a	ck	
9	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show avent, the Medical Exarts at rinal be inclified at	Completed	15. Deceder (Specify only highe	t's Education	l Inleted)		16a. Dece	dent's Usua	al Occupa	ition	t of working	na	16b.	Kind of Busine	ss/ind	ustry	
2	ithin	nple	Elementary/Secondary (0-12)		ollege (1-4	or 5+)		kind of wor DO NOT us			or mornin	<i>'</i> 9					
2	filed w Hygier ther th	Co	7th				Auto	Mech	anic					Private	9		
ב	tal H	Be	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	(First, Middle	, Maide	n Sumame)			
<u>}</u>	should be ind Mental is marked o	To		Ross								ce Jefi					
Mar	C1 (a = a		19a. Informant's Name/Relations				4							or Town, Stat			
e)	1 and Health em 27 thar tr		Gloria D.R. C	ieek/D	augnt			_			-	aurel,		yland Location - City			
وّ	Pages nent of h int: If ite		1 ☑ Burial 2 ☐ Cremation		al from Sta	ווט ן	Place of Dispo cemetery, crer			1							
Baltimore, Maryland 21215-0036	it. Partituding		' 4 □ Donation 5 □ Other (S)	Man	ryland	Natio Name an				3-04		urel,Ma			_
Ba	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of dilayar service	LICENSES /							ų.	B. Je Landove	nkir er,	ns Fune Maryla	ral	Home 20785	
Ž.	Physician /Medical		23a. Pert1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cau	Hype	h line.	ive Car						rrest,			Approximate Interval Betweer Onset and Death	1
	Examiner		Committee to the committee of		Cere	brovas	scular	accid	lent								
(e)	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or	as a consec	quence of):										
	acute ind trans	Examln	Cause (Disease or injury that initiated events resulting in death) Last	c			bstruct	ive I	Pulmo	nary	Dise	ease					
760,	ate be executed hysicien and he burial-transit		1830(ting 11 death) Last		Due to (or	as a consec	quence of):								4		
		dlcal		d													
9 ×	eath certifica attending ph for use as th	Physiclan/Med	IF FEMALE:	23c If	vas outco	me of pregn	ancy							M			
Box	atth atter for t	clan	23b. Was decedent pregnant in the past 12 months?	10	Live birth	1 2 ☐ Feta	al death 3	Ectopic pr						23d. Date of Month		y Day Year	
o.	0 0	ıysi	1 □ Yes 2 □ No 9 □ Unknown		Unknow			2 01.10. 100	,								
<u> </u>	that ned b deta		Part II. Other significant conditi	ns contribut	ing to deat	h but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco	use contribute	to the	cause of death	?
ecords,	n sign	d by										1 😡	Yes 2	!□No 3□	Proba	biy 4 🗆 Unkno	own
ဝ္ပ	w requires been si should I	lete							_			24a. Was	an	24b. Were	auton	sy findings avail	able
Жe	The law requires that the sate has been signed by the page 2 should be detached.	Completed											rmed?	prior death	to com	pletion of cause	of
	00	0	25. Was case referred to medica							26 Place	of Death	(Check only of	2X N) 1LJY	98 2	2 🔯 No	
		OB	examiner? 1 ☐ Yes 2 ☑ No	Hospita	al: 1 🗌 Inp	atient 2	ER/Outpatier	it 3□ DO	A Othe					6 ☐ Other (S	pecify		
0	ig Physter this neral di	T : U	27. Manner of Death		a. Date of I	njury Day Year)	28b. Time of Injury	2	8c. Injury Work	at		8d. Describe			,,		
Ö	ttending I death. ctor: After y the funer	atlc	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	gation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- Lay . Jan. /	,ury	М		es 2 🗆	No						
Division	7 0 0	Certification:	3 Suicide 6 Could 4 Homicide determ		e. Place of building,	Injury - At h	ome, farm, str	eet, factory	, office		2	8f. Location (City or To	Street a	nd Number or	Rural	Route Number,	
	pital or ours afte leral Dir filled in			1							1						
	he Hospital n 24 hours a he Funeral pletely filled	edical	29a. Certifier (Check only one)	Exeminer: O	the basis manner	s of examina	owledge, death ation and/or in	occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a th occurre	nd due to the d at the time,	cause(s date an	and manner d place, and d	as sta lue to	ted. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	6	2			29c	License	number	/ ~		29d. Da	ate signed (Mo	onth, D	ey, Year)	ĺ
`			Merter	de	AL				Vd	09	60		0	ct 2	0	200	1
_	(2)		30. Name and address of person						00 =				_		0		
			Norton Elso 31. Date filed (Month, Day, Year)	n M.D.					08 H	yatts	sviļl	e, Mar	yLar	nd 2078	2		
	Sta Registr		OCT 2 2 2	004	Sec	e A	ature	w									

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) OCTOBER **Physician** 2004 6:45P M GERALDINE SUE RHODERICK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 7, 19 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☑ F Director 220-28-2770 1933 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **show** ir than "naturel", or Items 23e or 28e-f show the Nedical Examination ust be multiled at 1 ☐ Yes 20 No Directo Maryland Frederick Rocky Ridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9309 Rocky Ridge Road 21788 United States death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Merital Hygiene. Importent: If item 27 le marked other than "naturel', or iten eny injury or other treumetic event, the Medical Examinations. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: white þ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) County School Board School bus driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Leo Miller Lillian Chipley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Rhoderick - husband 9309 Rocky Ridge, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10-25-2005 Frederick Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Brod 1621 Opossumtown Pike, Maryland 21702 e, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Usy only one caused in each line. 23a. Part1. Enter the disease, shock, or heart failere. L Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro Vascular 4 Thero SclenoTIE Priysician 30 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live hirth 2 Eetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð funeral director, page 2 should be Allure 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 🗆 No 1 Tes 2 No 1 Yas or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a

To the Funerel I

completely filled 1 🚾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0035152 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thurmont 丁. 乙. 5. 100 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 25 2004 Jense Registrar

		4	For State Registrar	State of Maryla	•	artment <i>rtificate</i>			and M	R	eg. No. U	04	35220
	Physicia	an	Decedent's Name (First, Middle, La LEON	st) ROGERS						2. Date of Dea Month OCTOBER	Day	Year 2004	3. Time of Death 12:45 A ^M
	/Medic Examin		4a. Fecility Name (If not institution, given HARFORD MEMORIAL					Location o			4c. County	of Death	
	Funeral Director	1	5. Social Security Number 6. S 086–18–4101	37	. last birthday,	If Under 1 Months	Days	If Under : Hours	Min.	8. Date of Birth (Month, Day 10V • 30	Year) 1932	Cour	lace (State or Foreign try) York
	within 72 hours after death with the Maryland ene. "naturel", or items 23a or 28a-f show than "naturel", or items 23a or 28a-f show to Medical Examinat must be notified at		Usual Residence of Decedent	ford 10c. C	City, Town or L	Aberde				1	Og. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 🕍 No
:	23a or	al DI	700 W. Bel Air	Avenue, Apt.				001			USA		
920	urs after dea al', or items	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1953		Was Decede If Yes, speci 1 Yes 2		spanic Origon, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, y : \mathbf{Bl}	etc.
21215-0036	should be filed within 72 hours after death with the Maylan and Mental Hygiene. The Maylan marked other than "natural", or items 23a or 28a-f show marked other than "hatical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+) 2	(Give	dent's Usual e kind of work DO NOT use ter Ca	k done d e retired	luring most)	t of workin		16b. Kind of B		
2	filed Hygi other	To Be Co	17. Father's Name (First, Middle, Las George Rogers							(First, Middle, Youngb		me)	
Mar	d 2 sho th and I to ma traume		19a. Informant's Name/Relationship Lucille E. Colem							<i>l Route Numbe</i> Havre de			
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Cont	20b.	Place of Disp cemetery, cre	osition (Nam matory or oth	e of her plac	θ)	D	22/04	20c. Location	- City or To	own, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Lice	ctt		552 I	Sco	tt Fu s Str	nera eet	l Home, Havre	de Grac	e, M	21078
	nysician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Ventricu	.lar	Fibril	of dyin	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	ate be executed EX III III III III III III III III III	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	yuence of):	Arte	14	Dı	seas				years
.O. Box 6	that the death certifics ed by the attending pt detached for use as t	Physiclan/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pre						ite of deliver	ery Day Year
rds, P.	quires that the signed by all be detacted	þ	Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying ca	use giv	en in Part I			bacco use con es 2□No		he cause of death?
Records,	The law requir ate has been si page 2 should I	Completed						<u>.</u>		24a. Was a autop perfor	sy med?	Were auto prior to co death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medicat examiner? 1 ★ Yes 2 □ No	Hospital: 1 Planation 2	☐ ER/Outpatie	ent 3 DO	Δ Oth	0.5		n <i>(Check only or</i>		ner /Snecii	(v)
o	ing Afte	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time		Bc. Injun Wor	at	1	28d. Describe h			,,
	i Diff	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, etc. (Spe	cify)					City or Tow	n, State)		al Route Number,
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	. 1 ~		30. Name and address of person w	completed cause of death (II	em 23a) (Type		700	7 10	p 64. (Octobe	er 21	, 2007
1	176		A. SPEVETZ, 501	SOUTH UNION A	AVENUE,		DE	GRAC	E, MI	21078			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 5 2	32. Registrar's Sig		marke							

10larlot 0045

State of Maryland / Department of Health and Mental Hygien 2004 35221 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 1429 OCTOBER 21 James Bruce Rice 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sacred Heart Hospital Cumberland
If Under 1 Year If Under 24 Hrs. Allegany 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Min 10 M 2□ F Days Hours Yrs. Director 232-24-3242 West Virginia 18-Aug-1918 Usual Residence of Decedent death with the Maryland 10a, State 10b. County item 27 is markad other than "natural", or iteme 23a or 28a-f show other treumatic evant, the Madical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Directo 1X Yes 2 □ No Maryland Allegany Longconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16002 St. Mary's Terrace Funeral 21532-12. Was Decedent Ever in U.S. Armed Forces?

1 ∰Yes 2 □ No If Yes, Give Year or Dates: UWT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item providents of the marked other than "natural, or item any injury or other treumatic event, the Madical Examinate and. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 ☑Widowed 4 ☐ Divorced Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) barber barber shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morgan Rice Rebecca Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12819 McCay Ave. daughter Mary Shircliff Cresaptown 21532-Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rest Lawn Memorial Gardens * 4 ☐ Donation 5 ☐ Other (Specify) 25-Oct-2004 LaVale Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lympholy CRUICEMM CHRONIC disease or condition resulting in death) Strut SYRS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any least a sequentially cause. Enter Underlying Cause (Disease or injury that initiated events One to for as a consucuence of Examiner the attending physicien and the for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 requires that the death certificate be Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ COMUNAMY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 22 No certificate 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 \(\text{Yes} \) 2 \(\text{D} \) to Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation death. 1 Tes 2 No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/IVA 156907 Holle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAS Harjit Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, Maryland 31. Date filed (Month, Day, Year) OCT 2 5 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 004 35222 1- State Amend Item 26 per Dr., G842, 040 26 if 25 the Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Vaar **Physician** October | 21, 2004 9:50 Elnora Rhodes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 ☐ M 2 DTF Director 83 May 28, 1921 463-40-6963 Rosebud, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show traumatic evant, the Medical Evar-ther must be notified at 1X Yes 2 □ No Maryland Prince Georges Clinton Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 20735 items 23a 4504 Stecoah Drive United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black 3 ₩ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife unk. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Spencer Brooks Lucille Elizabeth Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 4504 Stecoah Drive, Clinton, MD Rita Clinton othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State <u>o = 0</u> N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. City Cemetery 10/30/04 Levelland, Texas 21. Signature of Funeral Service Licenses 23 Name and Address of Facility Homes, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Forestuille, ind 20% Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart **Physician** angestive VRars /Medical a consequence of): Examiner oronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/21/04 1)0021326 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) are # A104 Clinton, MD 20735 Branch mo Elli 7700 Kodney L-31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 2 2004 Registrar OCT

State of Maryland / Department of Health and Mental Hygiene 004 35223 For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Frances Elizabeth Storey Year **Physician** October 18, 2004 2:45 A. M /Medical 4c. County of Death Allegany 4b. City, Town, or Location of Death Lonaconing 4a. Facility Name (If not institution, give street and number 15 G1IIS H1II Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 212-24-1311 1 M 2 X F 86 Maryland August 18, 1918 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State in than "netural", or items 23s or 28s-f show the Medical Examiner must be notified at Allegany Maryland Lonaconing 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15 Gills Hill 21539 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specity: White Baltimore, Maryland 21215-0036 Be Completed by 3 M Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Home 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Thompson 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Clarence Crowe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Juanita Fuente-Daughter 15 Gills Hill, Lonaconing, Md. 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 18, 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 2004 Cumberland, Maryland Cumberland Crematory `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee omes & Meke Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, Md. 21539 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac **Physician** 6 minates /Medical Due to (or as a consequence of): Examiner there 5 clesotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the buriat-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached t of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 2 No she al 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Certification: Injury Division Hospitel or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Devli MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.01

		1 = State Registrar		Ce	rtificate of	Death		Reg. No.	UU4	35221
Dhusi	-io-	1. Decedent's Name (First, Middle, La	ist)				2. Date of De		Year	3. Time of Death
Physi /Med	dical	Mary	Alice	Sears			Octob		2004	6:20 p
Exam		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	or Location of Death		4c. C	ounty of Death	_
		6185 Sandy Point		//		Frederick			Calvert	
Funera			1□M 2⊠F	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Cou	place (State or Foreig intry)
Directo	"	214-76-5817 Usual Residence of Decedent		32			June 1	6, 19	22 Mar	yland
yland now		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limit
Mar Mar	ţ	MD Calver	rt		Prince	Frederick				1 ☐ Yes 2 📉 N
th the	Director	10e. Street and Number			10f, Zip Code			10g. Citize	n of What Cou	ntry?
th will	le C	6185 Sandy Point	Road			20678			USA	
r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14	Race - Ameri Black, White,	
s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give	D [1 ☐ Yes 2 🔀 No				Soonih:	
Idition 2 1.2 1.3-00.30 Id be filed within 72 hours after death with the Maryland fental Hygiene. ked other than "natural", or items 23s or 28s-1 show it event, the Medical Examinat must be notified at	d be	15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occur	nation			MUI	
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e filed within all Hygiene.	E	Elementary/Secondary (0-12)	College (1-4or 5+	•)	none					
d be filed antal Hyg ed other	0	17. Father's Name (First, Middle, Last	")			18. Mother's Nam	e (First, Middle	, Maiden S	umame)	
Alenta Alenta rrked tic ex	To B	Joshua Lee	Sears			Blanche			Fa	arrell
Maryian d 2 should be th and Mental 7 is marked of traumatic eve	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Numb	er, City or	Town, State, Zij	p Code)
and elth elth		Ruth E. Clark, r	niece			t St., Up	per Mar			20772
es tanged Heelt if item 2		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other pla		Date	20c. Loca	ation - City or To	own, State
Pages ment of ant: If it		`4 □Donation 5 □ Other (Speci		Mt. Harm	ony Cemet	tery 10-22	2-2004	Owi	ngs, MD	20736
Daltimore permit. Pages 1 a Department of He Important: if item any injury or oth	j D	21. Signature of Funeral Service Lice	nsee		2. Name and Addre	•				
4054	a	William S	Choss			neral Hom			ngs, M	
	1	23a. Part 1. Enter the disease, or con shock, or heart failure. List only	pplications that caused to one cause on each line	the death. Do not en e.	ter the mode of dyir	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
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DOX ath cer attendir for use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	of pregnancy 2 □ Fetal death 3[⊒Ectopic pregnanc	v		23	d. Date of delive	•
b death of attention and for u	sicia	in the past 12 months?	4□Pregnant at ti 9□Unknown	ime of death 5	Other (specify)	,			Month	Day Year
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Ords, requires that seen signed be detailed	þ	Part II. Other significant conditions		t not resulting in the L	inderlying cause giv	en in Part I.			No 3 Prob	the cause of death?
w requires been sign	Completed	Hyperlipides	ma					165 2	140 3 F F F F	bably 4 Cunknow
10 E E C	dr	piabelles					24a. Was		24b. Were auto prior to co death?	opsy findings available empletion of cause of
VITAL FO							1 ☐ Yes	2	1 Yes	2☐ No
	Be	25. Was case referred to medical examiner?	Hospital:		ot all post Ott	26. Place of Deat				
Of Phys r this	7.	1 Yes 2010 27. Manner of Death	1 ☐ Inpatien	/ 28b. Time o	III 3 DOA	4 Nursing Ho	28d. Describe		Other (Specif	<i>(y</i>)
ISION C ttending P death. stor: After the funera	t lor	1 Natural 5 Pending 2 Accident investigate	(Month, Day	Year) Injury	of 28c. Injur Wor M 1	rk? Yes 2□No		,_,,		
JIVISION I or Attending after death. Director: Afte	fica	3 Suicide 6 Could not	28e. Place of Injur	ry - At home, farm, st	reet, factory, office		28f. Location (Street and	Number or Rura	al Route Number,
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	4 Homicide	building, etc.	(Specify)			City or To	wn, State)		
ospit hours unere ly fille		29a. Certifier Certifying P	hysician: To the best of	f my knowledge, dear	th occurred at the ti	me, date and place,	and due to the	cause(s) a	nd manner as s	stated.
he H in 24 he Fr	edical	one)	miner: On the basis of e and manner state	ed.						
To the Within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
		Matter	nep		Doc	58572		OctoL	su 19,	2004
A		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	Print)	· - L 211	0.	6.1	Sala sa.	00191
4	24	31 Days filed (Month Day Year)	au, 111) /1	Signature Porta	u Kd Sh	ute 310	mace	rnede	neum	0 206/8
Regi	State strar	OCT 2	2 1 2004	Constant K	free the	,				
DHMH 17 Rev		29b. Signature and title of certifier Walker 30. Name and address of person who Gwyneth A. Blatt 31. Date filed (Month, Day, Year)		Come No.	March	<u> </u>				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of	lealth and Death	Mental Hyg	jien 2 0 0 [35225
	Physici		1. Decedent's Name (First, Middle, Last)	iles			-	2. Date of Dea Month	th	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give shady Grove Ad		Hospita	4b. City, Town, or	Location of Deat	th	4c. County of	Death
	Funeral Director		240-07-4374	7. Ag	e (In yrs. last birthda 86 Yrs.	Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country) South Carol:
	Maryland f ehow ied al	or	Usual Residence of Decedent 10a. State 10b. County Md. Montgo	omery	10c. City, Town or	Rockvi	lle			10d. Inside City Limits 1 □XYes 2 □ No
	3a or 28a-	I Director	10e. Street and Number 9701-Veirs Dr			10f. Zip Code 2 0 8	350	1	0g. Citizen of Wha	at Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene, tiam 27 is marked other than "natural", or itams 23a or 28a-f ehow other traumente event, the Medical Examinet must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
21215-0036	within 72 horelene. Inan "natura The Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Git	edent's Usual Occup re kind of work done o DO NOT use retired lunteer	ation during most of wo		16b. Kind of Busin	ness/Industry
land 2	ould be filed Mental Hygi arked other atic evant, I	To Be C	17. Father's Name (First, Middle, Last) Raymond C. K	Celley,J				me (First, Middle, 1	Maiden Sumame)	-
Maryland	1 and 2 should Health and Men iam 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Ty Judith Baker- D			ling Address (Street 6				ate, Zip Code) , Va.22042
Baltimore,	Pages 1 a nent of Hea int: If itam iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dis cemetery, co Metropol	oosition (Name of ematory or other place itan Cre	ematory	Date - 10/21/	20c. Location - Cit	y or Town, State andria, Va.
Balti	permit. Pages Department of I Important: If its any njury or of once.		21. Signature of Funeral Sevi > License	90		22. Name and Addres	ss of Facility	Tna		
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the cause on each lin		nter the mode of dyin	g, such as cardia	c or respiratory arr	N.W., W.	Appr 1 te Interval Between Onset and Death
30,	/Medical Examiner bhysician and s the burial-transit	il Examiner	Sequentially list conditions, if any, leading to immediate cause. Early Uncerving Cause (Disease or injury that initiated events resulting in death) Last	Due to for as 60 we Due to for as Cofon	a consequence of): a consequence of): Cancer a consequence of):	ration				several years
.O. Box 68760,	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	f delivery Day Year
Ω.	quires that the n signed by th uld be detache	by	Part II. Other significant conditions cor	ntributing to death b	ut not resulting in the	underlying cause giv	en in Part I.			ite to the cause of death?
I Records,	ian: The law requires rtriicate has been sign stor, page 2 should be	Completed						24a. Was a autops perform	y prio med? dea	re autopsy findings available r to completion of cause of th?
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		on: 30 DOA Oth	or	ath (Check only on		
of	ding After fune	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Injur	+ □ Indising F	dome 5 ☐ Reside 28d. Describe ho	ence 6 Other ((Specify)
Division	al or Attandi s after death. Il Diractor: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At h <i>o</i> me, farm, : c. <i>(Specify)</i>	street, factory, office		28f. Location (St City or Town		or Rural Route Number,
	o tha Hospital or At vithin 24 hours after of tha Funaral Dirac ompletely filled in by	edical (29a. Certifier Certifying Physical (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner sta	examination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To thing on the or	Σ	29b. Signature and title of certifier	earte	MD	29c. License	15 4 9	2	9d. Date signed (A	Month, Day, Year)
K	10		30. Name and address of person who obtained Dr.Christine				Center	Dr.,Roo	ckville	,Md. 20850
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 5 2004	3 Registra	ar's Signature			,		

State of Maryland / Department of Health and Mental Hygiene, 35226 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 19 2004 Mary Frances Short 6:00 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Home Hyattsville Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth NOV. 3 1917 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 86 032-01-0559 Director Massachusetts Usual Residence of Decedent with the Maryland 10c. City, Town or Location in than "natural", or Items 23s or 28e-f ehow the Medical Examiner nust be notified at 10d. Inside City Limits XX Yes 2 No Funeral Director Maryland Pr. Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18511 Queen Ann Rd. 20774 U.S.A. death . Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural", or Item any injury or other fraumetic event, the Mudical Engine Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Boston School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernard Short Frances Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Gurlacz (Niece) 18511 Queen Ann Rd. Upper Marlboro, MD 20774 20a. Method of Disposition

→ Surial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Resurrection Cemetery10/25/04 '4 □Donation 5 □Other (Specify)

21. Signature of neral Service Licensee Clinton, Maryland 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner URINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physician and hed for use as the burial-transit certificate be executed -corressive that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Depression IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Degenerative Viscare 1 ☐ Yes 2 Probably 4 ☐ Unknown Gerebro 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 20 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ Xo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending death. 2 Accident investigation 1 🗌 Yes 2 🗆 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funerel Direct 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 10/22 04 D0051112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESMERANDU JUANTEZ 1160 VARNUM ST. A.E. WASHINGTON, D.C. 20017 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar 35227 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** WILLIAM DANIEL SLAGLE 5:45 P M /Medical OCTOBER 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK

| H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth
| Months | Days | Hours | Min. | Oct. 13, FREDERICK MEMORIAL HOSPITAL FREDERICK Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1**∑**M 2□F 220-03-9534 84 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Madical Examiner must be notified at 1√2 Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 430 Pinoak Place U.S.A. 21701 r death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1ऒYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter of Depertment of Health and Mental Hygiene. Introcrant: if Item 27 is marked other than "natural", or Itel mortant: if Item 27 is marked other than "natural", or Itel and Injury or other traumatic event, the Martical Examines and. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George C. Slagle, Sr. Margaret Gertrude Blumenauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Diane Butt (Daughter) 7413 Skyline Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery 10/26/04 Frederick, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signatur of Fully II Se Vice COBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that cause of shock, or hear failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sensu Priysician /Medical Due to (or as a consequence of) Examiner natur Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence The law requires that the death certificate be executed 181 PUSCO ig physician and as the burial-tran Due (r as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 TUnknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bornes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Renal 2 No 1 Yes al or Attending Physician: T s atter death. It Director: Atter this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3IT DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 T Accident 6 Could not be determined 3 Suicide within 24 hours atter de To the Funeral Directo completely tilled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HOO 6111 menero Donese 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francisco Daniels, HO, 400 West Seventh Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks OCT 2 5 2004 Jenson Registrar

			For State Registrar	State of Mar	ryland / Depa <i>Ce</i>	artment of F rtificate of	Health and Me <i>Death</i>	ental Hygien Reg. N		35228
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) $John$ D.	Smerick	ξ			2. Date of Death Month D	ay Year 2004	3. Time of Death 11:54 A M
	Examin		4a. Facility Name (If not institution, give s Civista Medica		r	4b. City, Town, o	or Location of Death		c. County of Death Charles	
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		plece (State or Foreign ntry) PA
	Maryland . f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Charle		10c. City, Town or Lo Waldorf	ocation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the I a or 28a- be colli	Director	10e. Street and Number	7.000		10f. Zip Code	(02	10g. (Citizen of What Cou	ntry?
36	I within 72 hours after death with the Maryland liene. Then "natural", or Itema 23e or 28e-f show The Maclical Exameter must be notified at	by Funeral	6124 Sea Lion P 11. Marital Status 1 Never Married 2 Married 3 Worldowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent of I	603 Hispanic Origin? (Specan, Mexican, Puerto For Specify:	cify Yes or No- tican, etc.)	USA 14. Race - Ameri Black, White, Specify: W	
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nd 2	file Hyg the	Be	17. Father's Name (First, Middle, Last)	4	rie	manic		(First, Middle, Maide		ines
Maryland	should ind Men inarke umatic	C	Peter Smerick 19a. Informant's Name/Relationship (Ty)			ng Address (Street	and Number or Rural	Smerick Route Number, City	or Town, State, Zij	o Code)
_	s 1 and 2 s if Health ar item 27 is other trau		Barbara Hocker/ 20a Method of Disposition	Daughter	612		ion Place		f, MD 20	
Baltimore,	permit. Pages Department of h Important: If ite any Injury or of		1 Nation 3 Representation MO	Maryland	matory or other pla 1 Vetera 2. Name and Addre AREHAR	ans $10/26$	5/04 Ch FUNERAL	eltenhar HOME,P	m,Maryland .A.	
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8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
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I Record	The law requires that the sate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performed 1 Yes 2	prior to co death?	opsy findings available ompletion of cause of
Vital	Physician: The this certificate har director, page	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	lospital: 1 Inpatien	t 2 ER/Outpatie	nt 3 DOA Ott	26. Place of Death	(Check only one)	6 ∏Other (Speci	fv)
ion of	ding Ph h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		of 28c. Inju		8d. Describe how in		,,
Division	in Site	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office	2	8f. Location (Street City or Town, Sta		al Route Number,
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	To the To the comp	Ň	29b. Signature and title of certifier		A. A	29c. Licen	se number		ate signed (Month,	Day, Year)
,			MC Carl		~)		3592	10	122/04	
	NR 21/1		30. Name and address of person who co Arnel C. Castre				Centre #	100 Wald	orf.MD	20602
	Sta Regist		31. Date filed (Month Cart Year) 2 2	004 32. Flegistrar	's Signature	ports	II	re top ats Cd	1	

		1.			Maryland / De	ertificate of			Reg. No	Int.	35220
Physic	ian	1.	Decedent's Name (First, Middle,		Allen Sloan Sr.		-	2. Date of Dea Month	Day	Year	3. Time of Death
/Medi Exami		4a	. Facility Name (If not institution,			4b. City. Town, o	or Location of Death	Octobe		2004 nty of Death	1130 a M
Exami	iei		Coney Cemetary		,		ing - Lona	coning		gany	'
Funeral Director			218-48-9147	3. Sex 1 ⊠ M 2□F	7. Age (In yrs. last birthda 57 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	r 12, 1946		place (State or Foreig intry) Maryland
e-f show	tor	10	sual Residence of Decedent Da. State 10b. County Maryland A	Allegany	10c. City, Town or	Location	Lonaconing				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
3a or 28 at be not	Funeral Director	10	De. Street and Number 20600 Wat	er Station Ru	n Road	10f. Zip Code	21539		10g. Citizen o	of What Cou US	
Department of Health and Mental Hygiene. Importent: if flem 27 is marked other than "netural", or flems 23a or 28e-f show any injury or other treumatic event, if a Mudical Exercities must be notified at 2006.	þ	11	. Marital Status 1 □ Never Married 2 23 Marrie 3 □ Widowed 4 □ Divorced	Armed Ford	ces? 2 ∑ No	3. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White,	
giene. er than "netu	Completed		15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		(Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retired Sej	pation during most of work d) ptic Service	ing	16b. Kind of	Business/Ir Sew	,
n and Mental Hygiene.	To Be (17	7. Father's Name (First, Middle, L	Charles Sloa	an Sr.		18. Mother's Name		Maiden Suma arcella Al		
h and 7 Is m treum		15	9a. Informant's Name/Relationshi Mysty SI		19b. Ma	iling Address (Street			-		
Healt tem 2 other		20	Da. Method of Disposition		20b. Place of Dis	position (Name of		Date	onaconing 20c. Location		
nt: ff I			1 ■ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specific Control of Contr		tate	rematory or other place n Family Cemet		october 19, 2004		-	,Maryland
Department of Health Importent: if Item 27 any injury or other tro		2	1. Signature of Funeral Service L	icensee		22. Name and Addre		00000-000000000	105065 107070	AS . 1 1	SH SONVENDIBUSE
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hysician /Medical xaminer e priial-Itausit	cai Examiner	In d	Shock, or heart failure. List o	a. Due to (c	used the death. Do not a chiline. The state of the state		ng, such as cardiac		The second secon	Lonaco	Approximate Interval Between
Medical xaminers and but and the attending physician and ched for use as the burial-transit	ш	Ind of the control of	snork, or hear failure. List of mediate Cause (Final isease or condition seuting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat initiated events	a. Due to (c b. Due to (c c. Due to (c d	or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of):	enter the mode of dyir	ng, such as cardiac o		23d. D	Lonacol Date of delivionth	Approximate Interval Between Onset and Death
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			The growth of th	ertificate of Death		N2004 35230	
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death	
	/Medic	al	Margie Gray Schneider 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October :	20, 2004 2:45 A M	
	Examin	er	2002 Cambridge Road	Crofton		Anne Arundel	
	Funeral		Social Security Number	If Under 1 Year If Under 24 Hrs.			n
	Director		579-32-3637 ^{1□ M 2} ▼F 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Mar. 19,	1927 Ohio	
	pug 🔉		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits	_
	Maryli f sho	ō	Maryland Anne Arundel Crofton			1 G√Yes 2 No	
	the 128a-	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?	_
	h with	ai Di	2002 Cambridge Road	21114-1937		U.S.A.	
	deat	Funeral		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.	
36	or Ita	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ZNo Specify:		Specify: White	
Ö	hour tural'	q pa	3 ☐Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	161	b. Kind of Business/Industry	_
5	n "na	plet	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	b. Nino of Business moustry	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vithar than "natural", or Itams 23a or 28a-f show sitt, the Madical Exercitmer, sust be notified at	Completed by		Home Maker		Own Home	
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	iden Sumame)	
yla	ould i	2	Robert Reed Gray		elyn Roth		_
Maryland	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Exercitive fractional for notified any once.			ling Address (Street and Number or Rur Cambridge Road Cro			
	Heat Heat tam 2		20a. Method of Disposition 20b. Place of Disposition	position (Name of		c. Location - City or Town, State	_
Baltimore,	Pages ent of nt: # i		1 Burial 2 Cremation 3 Removal from State Staf. 4 Donation 5 Other (Specify) Memorial	ord 10/20	0/04	tafford, Virginia	
alti	permit. I Departm Importa any inju		ricinorial	22. Name and Address of Facility Rol	pert E. Ev	vans Funeral Home	T
<u> </u>	P P P P P P P P P P P P P P P P P P P		JANKS	16000 Annapolis Roa	ad Bowie,	Maryland 20715	1
П			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	aortic anew	rysm	1070005	
	/Medical Examiner		Due to (or as a consequence of):	- Air Or	- Pica	20218	
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	ruccine en	g anger	2026	
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x 68	death certifica e attending ph id for use as th	Completed by Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				_
Вох	that the death certific ed by the attending p detached for use as	clan	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
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٣.	ires that signed b d be deta	y Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?	
rds	w require been sig should b	ed t	Diabeles mellitus		1 Tes	2 No 3 Probably 4 □Unknown	
Records,	The law requires that the site has been signed by the bage 2 should be detached.	plet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
- H		Con			performed	d? death?	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	Othor	h (Check only one)		
of	P + F	2	T Tes 2 No	ant 3 DOA 4 Indising no	me 5 Residence 28d. Describe how i	e 6 ☐Other (Specify)	-
on	Attending Phyrr death. actor: After thi	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,	
Division	Attendi ir death. actor: A by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number,	
	tal or rs afte al Dir	Certification:	uniding, see. (Specify)		ony or rown, o		
	To the Hospital or Attendi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dei (Check only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.				
	To the within To the comp	Me	29b. Signature and title of certifier Attending Physicia	29c. License number 4D 944973		Date signed (Month, Day, Year) + Chel 20, 2004.	
•			30. Name and address of person who completed cause of death (Item 23a) (Type				
			GURMEET S. SAWINEY MD	Glen Burne	, MD	21061	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	OCT 2 0 2004	back			

	State of Maryland / Department of Health and N 1- State Registrar Certificate of Death	Mental Hygien 2004 35231
	Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Physician /Medical	Ernest Anthony Topolski	Month Day Year 1800 M
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
	Peninsula Legional Medical Center Salisbury	Wiconico
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year of Under 24 Hrs. Nonths Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania
Director	159-32-6555	1/25/1941 Pennsylvania
32 yland yland	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Many Many stor	Maryland Wicomico Eden	1 ☐ Yes 2 🖾 No
Vih the Marylar or or 28a-1 show be notified at Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
death with the Maryland ms 23a or 28a-1 show traust be notified at a rerail Director	3605 Allen Road 21822	USA
5 Miter death verifiems 23 directment	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14 Fee, specify Cuban, Mexican, Puerto 17 Fee, Specify Cuban, Mexican, Puerto 17 Fee, Specify Cuban, Mexican, Puerto 17 Fee, Specify Cuban, Mexican, Puerto 17 Fee, Specify Cuban, Mexican, Puerto 18 Fee, Specify Cuban, Pue	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
036 urs after all, or i in the by Fi	1 □ Never Married 2 ② Married 1 ③ Yes 2 □ No Guard 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify	Specify: White
21215-0036 by Promise in the manual properties of the manual promise of the manual promi	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
215 215 215 215 215 215 215 215 215 215	Flementany/Secondary (0.12) College (1-4or 5+) life. DO NOT use retired)	
21215-00 ed within 72 hou ygjene. Per than "naturalit, the Medical Ed., the Medical Ed., the Medical Ed.	12 - Service Technicia	an office machines
Ind Ind of other evant		e (First, Middle, Maiden Sumame)
SKT AM M. M. M. M. M. M. M. M. M. M. M. M. M.	Anthony Topolski Anna	
Baltimore, Maryland 21215-0036 Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene importent: if term 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Joann M. Topolski/wife 19b. Mailing Address (Street and Number or Run 3605 Allen Rd., Ed	al Route Number, City or Town, State, Zip Code)
Ore, Mose 1 and 2 tof Health If item 27 or other tra	20b. Place of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Por ages and of the life if the your of	1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	0/21/04 Salisbury, MD
nit. P	21. Spriature of Europeal Service Licensee 221 Name and Address of Eacility	1 Home Dreferriers Acces
Bal Bal Dermi	David H. Gompon, CFSP 501 Snow Hill R	al Home Professional Asso Rd., Salisbury, MD 21804
445400	23a. Part1. Enter the disease, or complicitions that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on sach line.	or respiratory arrest, Approximate Interval Between
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/Medical	resulting in death) Due t (or as a consequence of):	
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Box eath cert attending for use a	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	23d. Date of delivery
o deat deat of for ed for sicial	in the past 12 months? 1 Tes 2 10 Unknown	Month Day Year
P.O. hat the de dd by the detached detached Physic	9 Unknown	23e. Did tobacco use contribute to the cause of death?
I Records, P.O. Box 68 The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
Orc requi		
Record The law requir te has been si age 2 should		24a. Was an autopsy autopsy findings available prior to completion of cause of death?
Vital Re isiclan: The is certificate ha: rrector, page 2	Of Wasses whered to medical	1 Yes 2 No 1 Yes 2 No
Division of Vital Records, tor Attending Physician: The law requires talter death. Director: Attenthis certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	examiner?	th (Check only one) ome 5 Residence 6 Other (Specify)
g Physic grithis of eral director	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how injury occurred
rision (Manding F death. ctor: After y y the funera	2 Accident investigation M 1 Yes 2 No	
Division C state death state death at Director: Alter t ed in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dittel o		
ne Hosp n 24 hou he Funei pletely fil	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one)	and due to the cause(s) and manner as stated. Tred at the time, date and place, and due to the cause(s)
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director.	29b. Signature and htte of certifier 29c. License number	29d. Date signed (Month, Day, Year)
F 3 F 0	D1943>	10/19/04
NA	30. Name and address of nescon who completed cause of death (Item 23a) (Type, Print)	0 (11)
1341	Theos & Dan SEO KWENICLE IN 1102	2 Delisbury 170 21801
State Registrar	31. Pate filed (Month Car Year) 1 2004 32. Registrar's Signature & Apacks	ć

State of Maryland / Department of Health and Mental Hygien 2004 35232 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8:45 p October 2004 Tool Clements /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5124 Holly Drive West River Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Davs Months Hours 1 ☐ M 2 💢 F 82 219-12-4628 Nov 9, 1921 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or than "natural", or Items 23a or 28a-f shov the Medical Example: ...ust be notified at 1 ☐ Yes 2 No Director MD Anne Arundel West River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5124 Holly Drive 20778 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) p rriit. Pages 1 and 2 should be fill Department of Health and Mental H. Ir pcrtant: If item 27 Is marked ott any injury or other traumatic even Be Clements Anna ၉ Clarence Joseph Grace Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arthur Q. Tool, spouse 5124 Holly Drive, West River, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10-21-04 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service L 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): ner as the burial-transit requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) detached P.0. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Division of Vital Records. þ pe 1 Tes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No 1 ☐ Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No P nours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Zivatural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a fo the Hospital ticcritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0006054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shaby Side Rd 20764 ONES, mo 10 32. Registras Signature 31. Date filed (Month, Day OCT State Registrar

		,	For State Registrar	State of M		partment of He <i>rtificate of L</i>			iene 2004	35233
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	125942	Z			2. Date of Death	Day 200	
	Examin		4a. Facility Name (If not institution, given Villa Rosa Nu)				Location of Death		4c. County of De	Georges
	Funeral Director		032-30-0364	ex 7. A	ge (In yrs. last birthda 68 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct • 1	9. B 4,1936 F	Sirthplace (State or Foreign Country) Puerto Rico
	f show	or	Usual Residence of Decedent 10a. State 10b. County Md. Prince	Georges	10c. City, Town or	Location he11vi11e	9			10d. Inside City Limits
	s with the N 3a or 28a-	I Director	10e. Street and Number 3800 Lottsfore	d Vista	Road	10f. Zip Code	0721	10	0g. Citizen of What	Country?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 le markad other then "natural", or itams 23a or 28a-f show other treumatic event, the Medical Examinational Le notified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 27 If Yes, Give Year or Dates:	t Ever in U.S. 1: ?	3. Was Decedent of H If Yes, specify Cuba	Specify: Pu	erto	Black, W	nerican Indian, hite, etc. ispanic
21215-0036	within 72 ho 8ne. then "natur the Medical I	Completed	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+) (Gi	cedent's Usual Occupi ve kind of work done o b. DO NOT use retired gistered	ation during most of workii l)		16b. Kind of Busines Hospi	
	2 should be filed within and Mental Hygiene. I e markad other then reumatic event, the M	Be Co	17. Father's Name (First, Middle, Last,		I KC	gistered	18. Mother's Name	(First, Middle, N		
Maryland	should be and Mental markad o umatic eve	To	Juan Vasquez 19a, Informant's Name/Relationship (Type Brint)	10h Me	illing Address (Street	Dolore		City or Town State	7in Code)
	1 and 2 si Health and tem 27 le r		Alex Martinez	(Son)		uling Address <i>(Street a</i> 602 Pook 6 per Mar 11		ryland	2077	1
3altimore,	Page ent o nt: If ry or		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif			per Marll position (Name of rematory or other place easant Ce		ate	20c. Location - City	
Balt	permit. Popartm Importar any inju		21. Signature of Funeral Service Licer Calph 2.	Willes	101		omac Ave	., SE; 1	Washingt	on, DC 2000
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ľ	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Colors of injury	b. 12/09	s a consequence s):	Lupan	Desar	Pal	psy	years years
8760,	tate be executed by sician and the burial-transit	dical Exa	that initiated events resulting in death) Last	d. Due to (or a	s a consequence of):	mellita	<u></u>			years.
O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page? should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown		2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	,		23d. Date of o Month	delivery Day Year
0	quires that t n signed by uld be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in the	e underlying cause give	en in Part I.			to the cause of death? Probably 4 (Unknown
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Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital:	Section of SECONA	oth	26. Place of Death			
of		atlon: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpat 28a. Date of In (Month, D		e of 28c. Injury			ence 6 Other (S) w injury occurred	рөспу)
Division	Hospitel or Attending 4 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	288. Place of I	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (St. City or Town		Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 M Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the bes miner: On the basis and manners	of examination and/or	eath occurred at the tin investigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner ate and place, and d	as stated. lue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	J.Ki	m, MiD	29c. Licens		25	9d. Date signed (Mo	onth, Day, Year)
R	(7)		30. Name and address of person who	completed cause of	death (Item 23a) (Type	pe, Print)	5	largo	M.D o	2111
		ate	31. Date liled (Month, Day, Year)		trar's Signature	auth e			2	-//-
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Physician

/Medical

Examiner

Funeral

Director

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other traumatic event, the Medical Examiner of

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Maryland 21215-0036

Baltimore,

Funeral Director

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To the Funeral Direct the

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of

Afier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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- Road Rule 2030 Wolder

			1 - State of Maryland / Department of Maryland	artment of Health and tificate of Death	Mental Hygier Reg. I	2004 35235
	Physicia /Medic	al ·		h, te 4b. City, Jewn, or Location of Dec	Drober !	Day 1 Year 17.1410M 4c. County of Death
	Examin Funeral Director	er	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 224-38-3171	If Under 1 Year If Under 24 Hi Months Days Hours Mil	s. 8. Date of Birth	9. Birthplace (State or Foreign Country)
	ס	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	1/9/33	10d. Inside City Limits
	with the Ma 3a or 28a-f	Funeral Director	MD Prince Georges New Car 10e. Street and Number 7710 Topton Street	10f. Zip Code 20784		1 X Yes 2 □ No Citizen of What Country? USA
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural', or items 23a or 28a-f show any righty or other traumatic event. It is Modified Examination on the Design of the Design of the Control of the Design of the Control of the Design of the Control of the Design of the Control of the Cont	6	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	Was Decedent of Hispanic Origin? of Yes, specify Cuban, Mexican, Pus 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: black
21215-0036	within 72 hou ane. than "natura	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of w DO NOT use retired) tronic Tech	orking	: Kind of Business/Industry
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Maryland	nd 2 shou ilth and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or I	Rural Route Number, Cit	y or Town, State, Zip Code) 1ton, MD 20784
altimore,	Pages 1 ament of Healent: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	sition (Name of natory or other place)	Date 20c. /25/04 Bre	Location - City or Town, State
Balt Balt	Depart Depart Import any inj		1 Mille / Menry 4.	Name and Address of Facility K Henry Fune: 20 H Street NI	s wash bc	Inc. 20002
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68760,	cate be executed physician and physicial-transit sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying hat initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			4 days
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1	To t To t	ž	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
· ·	1		30. Name and address of person who completed cause of death (Item 23a) (Type,	RES-000 Print)	60	tober 19,2004 0 North Wolfe Street
N	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 5 2004	Tower 110 Doctors	Lounge Ba	lhimore, May land 21287

		For State Registrar	State of Ma	aryland	/ Depa	artmen tificat	t of H	ealth a Death	and M		Reg. No.	004		
Physicia /Medica Examine	al	Decedent's Name (First, Middle, Last, HAROLD WILLIS 4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	f Death	2. Date of Dea Month October	Day 20,	Yeer 2004 ounty of Death	3. Time of De 5:10 p	м
Funeral	1	5914 Riverside D	rive	(In yrs. la			verd	ale If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Day June 14	Pri	nce Ge	place (State or Fountry)	oreig
Director work	_	Usuel Residence of Decedent 10a. State 10b. County		80 10c. City,	Yrs. Town or Lo					June 14	, 1924	4 Ber	10d. Inside City L	Limits
with the Ma Se or 28a-f	Direc	Maryland Prince Go 10e. Street and Number 5914 Riverside D:		Ri	verda	Le 10f. Zip		20737			10g. Citizer	n of What Cou	1½ Yes 2	
	by Funeral	11. Marital Status 1 Never Mamed 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 MYes 2 □ N If Yes, Give Year or Dates:		1	Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ocify Yes or No- Rican, etc.)	1	Race - Amer Black, White pecify: W		
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Maryland & Market and Market and Mental Hygists and Mental Hygists is market other traumatic event, ill	To Be C	17. Father's Name (First, Middle, Last) John Henry Willi: 19a. Informant's Name/Relationship (Ty			19b. Mailir	a Address	(Street a	Mary	Eli	(First, Middle, Za Tart I Route Numbe			ip Code)	
ges 1 and 2 s t of Health an if item 27 is or other trau		David W. Willis - 20a. Method of Disposition 1 △Burial 2 □ Cremation 3 🏖 F	- Son	20b. Pla		non l	Road	, Fal	mout	h, Virg	inia 20c. Locat	22406 tion - City or T	own, State	
paritimore, in permit. Peges 1 and Department of Health Important: if item 27 eny injury or other tr		*4 Donation S Other (Specify) 21. Signature of Funeral Service Licens		Rose		. Name ar	d Addres	s of Facility	Ga	4/2004 sch's F , Hyatt	unera	1 Home		1i
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Hospitel or Attending 124 hours after death. Funeral Director: After	al Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc	:."(Specify)				e date and		City or Tow	n, State)		al Route Number,	
To the Hospitel within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Exemi	ner: On the basis of and manner sta	examination ted.	n and/or inv	estigation	in my op License D476	number	h occurre	ed at the time, o	date and pla	igned (Month,	o the cause(s) Day, Year)	
2 (12) Wa	te	30. Name and address of person who co Charlotte Dean, MI 31. Date filed (Month, Day, Year)	6525 E	Belcre	est Rd	., Hy	yatts	sville	∍, MI	2078	2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For Stete Registrer 35237 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month HERMAN WILLIAMS 11:20 A M October 19 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care of Largo Largo Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs 577-14-7191 Director 97 August 2 1907 South Carolina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits or 28a-f show item 27 is marked other then "neturel", or items 23e or 28e-f show other treumstic event, the Medical Examiner mast be notified at 1x Yes 2 □ No Prince George's Landover Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1511 Ballinger Avenue death v 20785 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 3rd College (1-4or 5+) of Health and Mental Hygiene. Mechanic Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy, importent; if item 27 is marked othe any injury or other treumaric event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Williams/Son Ballinger Avenue Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State Riverdale Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 10-21-04 Riverdale, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ACUTE MYSCARDIAL INFARCTION
Due to (or as a consequence of): /Medical Examiner DEMONTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown care has been signed; page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 X No 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 💢 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospitei or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-17874 N-SN 10-20-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3717 38th Avenue Cottage City, Maryland 20722 Sankaran Nayar M.D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2 2 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Chan King Chee Woo 21 2004 0ct /Medical 10:12 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Clinton

If Under 1 Year | If Under 24 Hrs.

Page | Hours | Min. Southern Maryland Hospital Prince George's

9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Hours 1□M 2□F 567 74 7554 June 1, 85 1919 China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Montgomery 1 ☐ Yes v² ☐ No Directo Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2312 Homestead Drive by Funerai 20902 United States
14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify: X Widowed 4 □ Divorced Chinese Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chan Houn Jeun Wong Soy Kam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia O. Woo (Daugher) 3058 Ohara Place, Olney , Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 27, D2004 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Borial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Fort Lincoln Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Micology Alexandria Ferry Rd, Clinton, Maryland 20735 trans and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Litter or derilying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown BREAST CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPER TENSION 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JOSRIE D 40324 OCTOBER 22,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JODRIE, M.D. 7503 SURRATTS ROAD, CLINTON, MARYLAND TERRY

State Registrar

31. Date filed (Month,

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ia any injury or other trau

Physician

/Medical

Examiner

use as the burial-transit the attending physician and

Hospital or Attending Physician: The law requires that the death certificate be executed

been signed by

filled in by the funeral director,

Director: After

Division of Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

		•	1 - For Amend Item 285 per me	a 6838 12	Certificate of	neaith and M Death	ental Hygie Reg.	2004	35239
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	/Medio Examin		Jonathan Douglas W 4a. Facility Name (If not institution, give street and number,)	4b. City, Town, o	or Location of Death		4c. County of Death	
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	th with the 23a or 28 ust be no	Funeral Director	332 Highland Terrace		10f. Zip Code 20678	3		Citizen of What Co	
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and	ould be fil Mental H larked oth	To Be	17. Father's Name (First, Middle, Last) Thomas Douglas White			18. Mother's Name Arden St		iden Sumame)	
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_	To the Hospital within 24 hours a To the Funaral Completely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the bes 2 Medical Examiner: On the basis and manner and manner	st of my knowledge of examination an	e, death occurred at the tod/or investigation, in my	me, date and place, a	and due to the caus	se(s) and manner as	stated.
)	To the within To the comple	Me	29b. Signature and title of certifier		29c. Licen O • C • I			Date signed (Month Ctober 20	
	ID		30. Name and address of person who completed cause of NA RVA10, HD				et, Baltin	more, Mary	yland 21201
	Sta Regist		31. Date filed (Month, Day Year) 2 1 2 004	tras Signature	& South	•			

			State of Maryland	d / Department of Health and Me Certificate of Death	ental Hygien	2004 35240		
ı	Physici /Medic		Decedent's Name (First, Middle, Last) Kenneth William Winebrenner, Sr.	:		3. Time of Death 3.4, 2004 11:30 A-M		
	Examin		4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL	4b. City, Town, or Location of Death Cumberland	/	c. County of Death ALLEGANY		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In the security Number) 1217-30-2178 Usual Residence of Decedent	ast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	3. Date of Birth (Month, Day, Yea 30-Jul-1934			
	Maryland -f show	tor	10a. State 10b. County 10c. City	, Town or Location		10d, Inside City Limits 1 ✓ Yes 2 □ No		
	h with the	Funeral Director	10e. Street and Number 16101 Reds Lane, NW	10f. Zip Code 21545-	10g. C	Citizen of What Country?		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel', or Items 23e or 28e-f show appringury or other treumetic event, it is mydical Exambar must be nettlined at ance.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Never Status 12. Was Decedent Ever in U.S Armed Forces? 1 Nover Status 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Nover Status 12. Was Decedent Ever in U.S Armed Forces? 1 Nover Status 12. Was Decedent Ever in U.S Armed Forces? 1 Nover Status 1 Divorced 1 Nover Married 2 Nover Status 1 Nover Married 2 Nover Status 1 Nover Married 2 Nover Status 1 Nover Married 2 Nover Status 1 Nover Married 2 Nover Status 1 Nover Married 2 Nover Status 1 Nover Married 2 Nover Status 1 Nover Married 2 Nover Status 1 Nover	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White		
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	and 2 sho ealth and i n 27 is mu		19a. Informant's Name/Relationship (Type, Print) Jeanette Winebrenner wife	19b. Mailing Address (Street and Number or Rural. 16101 Reds Lane, NW Mt. Sc		or Town, State, Zip Code) Maryland 21545-		
Baltimore,	t. Pages 1 attent of He tent: If Item		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		te 20c. ct-2004 Flint	Location - City or Town, State stone Maryland		
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Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined.	Injury Work? M 1 ☐ Yes 2 ☐ No me, farm, street, factory, office 28	d. Describe how injustif. Location (Street a	and Number or Rural Route Number,		
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			001 20 2007	~ REPORKS!				

			1 - For State Registrar	State of Mary	land / Depa	artment of I	Health and Death		gien 200 L	35241
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	Funeral	E 8 .	Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours M			irthplace (State or Foreign Country)
	Director		1/3-14-3252	□ M 21XF 8	34 Yrs.					ennsylvania
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Z	and 2 salth a n 27 ls		Thomas Yarbrough	(Son)	3314	Michele 3	Lane, Mi	tchellvil	Lle, MD 20	721
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altimore,	Pages Jent of Int: If It Iry or o		1 ⊈Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	nemoval mom state		Heaven C		26-04	Silver Sp	rin MD
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و	leath certificate be executed attending physician and I for use as the burial-transii	73	IF FEMALE:							70
ž	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐		Ectopic pregnance	v		23d. Date of d	
	ed fo	Sici	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)			Month	Day Year
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Ś	es th ignec be d	þ	Part II. Other significant conditions of	-	_			11	_	to the cause of death?
ecords,	equir en s ould	Completed	Urusepsis-Large	infected sad	cral deci	bitis ul	cers	1 Y	es 2 No 3 I	Probably 4 Dinknown
ပ္ထ		ple						24a. Was a autops		autopsy findings available o completion of cause of
T	The ate his	mo.						perfori	med? death?	
Vital	alcian: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical				26. Place of D	eath (Check only on		
	> <u>~</u>	To E	examiner? 1 ☐ Yes 2 █️¥No	Hospital: 1 XInpatient	2 ER/Outpatier	t 3 DOA Oth	er: 4 🗆 Nursing	Home 5 Reside	ence 6 □Other (Sp	ecify)
סר	ding Ph h. After th funeral		27. Manner of Death 125€ Statural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe ho	ow injury occurred	
ō	Attending r death. ector: After by the fune	atlc	2 ☐ Accident investigation				Yes 2 □ No			
UNISION	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (St	At home, farm, str	eet, factory, office		28f. Location (St City or Town	treet and Number or F	Rural Route Number,
2	italo rsaft al Di	Certification:		edment a						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier Certifying Ph	ysician: To the best of my niner: On the basis of exam	knowledge, death	occurred at the tir	me, date and pla	ce, and due to the c	ause(s) and manner a	as stated.
	the Frin 24 the Friplete	ledi	one)	and manner stated.						
	To To Com	Σ	29b. Signature and title of certifier	· Lu-		290 Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
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e	- (ID)		30. Name and address of person who			Print)		0 1 1	. (.	2 174
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State Registrar 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Mary Evelyn Maxwell Yearian 0758 AM October /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Elkton Cecil 205 Skipjack Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs. Director 79 1925 West 224-24**-**9611 Virginia Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in then "naturel", or items 23a or 28e-f show the Modical Examiner must be notified at 1 X Yes 2 ☐ No Maryland Cecil Elkton Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 205 Skipjack Court Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 0. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker In Her Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event 2008. Pauline McFarlane Denny Hansford Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Maxwell/Daughter 4570 Petaluma Avenue, Lakewood, California 90713 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cametery, crematory or other place)
G1Ipin Manor
Memorial Park October 27, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 2004 Elkton, Maryland 21. Sign ure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. bas 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Notestate Overian Concer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760, Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1) Yes 2 No 3 Probably 4 Unknown solorestal Concer 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Hypertension 1 Tes 2 No Division of Vital To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Statesidence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide after within 24 hours a To the Funerel L 29a. Certifier 🞁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DD056327 10/25/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cichey T Teal m

31. Date filed (Month, Day, Year) III West High Street Ste 312 Elkton 32. Registrar's Signature State Registrar

ORIGINAL

680 and

> Records, P.O. of Vital Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registra 35243 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0256 october GLORIA JEAN ZUEGER 23,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Peninsula Reginal Medical Center Sallo 6 UV q Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2**X** F Hours Min. 63 Director 9/7/1941 215-38-0891 MD Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28e-f ehow coust be notified at Director 1 Yes \\o Worcester MD Girdletree 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7241 Cherrix RD USA or Items 23e 21829 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) The Mudical Examiner filed within 72 hours after ∏Yes 2 **X**√Vo fYes. Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 'neturel' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other treumetic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H and 2 should be Clinton George Holland Myrtle Mae Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 le Dorothy Zueger 7241 Cherrix RD Girdletree, MD 21829 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XBurial 2 Cremation 3 Removal from State ō permit. Page Department o Importent: If eny injury or Whatcoat Cemetery 10/26/04 * 4 ☐ Donation 5 ☐ Other (Specify) Snow Hill, MD 21. Signal Te of Fune 22. Name and Address of Facilithe Burbage Funeral Home Service Licens 208 W. Federal St. Snow Hill, MD 21863 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tac /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-transil Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţō in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 4 No To the Hospitel or Attending Physicien: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} within 24 hours a To the Funerel (Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number completed cause of death (Item 23a) (Type, Print 100 6 11.0 SIMONA 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

			1 - For State Registrar	State of M	aryland		artmen tificate			and N			04	35244
	Physici		Decedent's Name (First, Middle, Las Rando lph E. Andre	•							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give			Location o	of Death	Novembe	1 77	2004 ity of Death				
			Union Memorial Hospit		no (la una la cu	a forinale new col	Ba1	timor	e If Under:	24 Hrs	0.0	NA.	1	
	Funeral Director		5. Social Security Number 6. Sp. 219–50–3937	7. A M 2□F	ige (In yrs. lasi 55	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 05-08-194	Year)	9. Birth Cou Mary	place (State or Foreigr intry) (Land
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	'aum as la	cotice							
	Maryla f shor	lor	MD NA		Balti		Cation							10d. Inside City Limits 1 Yes 2 □ No
	or 28a-	Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·	Derica	IIOIC	10f. Zip	Code				10g. Citizen o	f What Cou	intry?
	ath wit	ralD	2883 Pelham Avenue					21213					USA	
36	within 72 hours after death with the Maryland liene. r than "natural", or itama 23a or 28a-1 show the Medical Examinar must be rodified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 I If Yes, Give Year or Dates:	?]No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White lify: Black	
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121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us Machin				9	M-	ilitary	7
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ylan	D to D .	To B	Willie Melvin Avery	0.000						Wil	llie Mae A	ndrews		
Maryland 21215-0036	and and s m		19a. Informant's Name/Relationship (7								al Route Number		n, State, Zij	p Code)
	s 1 and 2 f Health itam 27 I		Deborah R. Andrews/ W 20a. Method of Disposition		l com	e of Dispo	Peinal sition (Nam natory or oi	ne of	T		ore, MD 21 Date	.213 20c. Location	n - City or T	own, State
m	000		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		B !		orest			1-15-	-04	Owings 1	Mills,	MD
Baltimore,	permit. Pag Depertment Important: I any injury o once.		21. Sign that Funeral Arvice Licen	Mall	1-		Name an Wylie			,	N. Gilmo	r St. Ba	alto, M	1D 21217
Ì,	Pnysician		23a: Part 1. Enfer the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cause one cause on each	ed the death. I	Do not ent	er the mode	of dying	, such as	cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
8760, <	/Medical Examiner physician and the purial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Como Due to (or a	s a consequent	ice of):	Cquir	ad	pau	ums	010		17	byears_
.O. Box 68	he death certific the attending p thed for use as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal de at time of deatl	ath 3	Ectopic pro						ate of deliv	ery Day Year
<u>α</u>	w requires that the bear signed by should be detact	by	Part II. Other significant conditions of	ontributing to death	but not resultir	ng in the ur	nderlying ca	ause give	n in Part I.		23e. Did tol	_	-	the cause of death?
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ion	Attanding Ph r death. sctor; After th by the funeral	atloi	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	1	ay Year)	Injury	М		? 'es 2 □1	No				
Division	Dir	Certification;	3 Suicide 6 Could not be 4 Homicide determined	289. Place of ir	njury - At home etc. <i>(Specify)</i>	, farm, str	eet, factory	office			28f. Location (St City or Town	treet and Num n, State)	ber or Rura	al Route Number,
	To the Hospital within 24 hours of To the Funaral to completely filled	edical	(Check only 2 Medical Examone)	ysician: To the bes liner: On the basis and manner s	of examination	dge, death and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, h occurr	and due to the ca ed at the time, d	ause(s) and mate and place	nanner as s , and due to	stated. o the cause(s)
L .	To t To t	Σ	29b. Signature and title of certifier Gram Vella Re	chawan	MD			License		1. 1		9d. Date sign		Day, Year) th, 200 H
,			30. Name and address of person who	,		la) (Tuna					VERSIT			, 2007
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State of Maryland / Department of Health and Mental Hygiene 004 35245 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Rose Bullock NOVEMBER 4, 2004 2:20P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12529 GRACEWOOD ROAD CHASE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 24, 1953 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min. NorthCarolina 1 M 2 S F 213-62-5178 Yrs. 50 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 X No MD Baltimore Chase Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12529 Gracewood Road USA 21220 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:White þ 3 Widowed 4 Divorced "neturel" ieted the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Compi Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental H tent: If item 27 is marked ott jury or other treumatic even Be Robert Brown Carolyn Condor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Brown / daughter 4020 Silvage Road PerryHall MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or ot
once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Baltimore MD Bayview Crematory 11/8/04 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service License On 300 Mace Ave. Baltimore MD 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final notquen ntraora Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 ♥ Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ pe No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes certificate 2□No Division of Vital To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 XYes 2 No this 28b. Time of Injury PM 28c. Injury at Work? 28a. Date of Injury ("Jonth, ay Year) 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 🗀 Natural 5 Pending 281. Locatio (Street and Number or Rural Route Number, Rd. City or Town, State) (2539 Gracus Add 0404 1 ☐ Yes 2 🗖 No within 24 hours after death. To the Funerel Director: A Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by hase Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 X Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. NOVEMBER 5,2004 ted cause of death (Item (3a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiens, 35246 For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Mildred C. Bortel Nov 2:05 a M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Charlestown Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year **Funeral** Months 1 ☐ M 2 🔀 F 92 Feb 17, 202-03-1643 Pennsylvania Director 1912 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f shov Examiner must be notified at Catonsville 1 ☐ Yes 2X No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 719 Maiden Choice Lane 21228 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Completed by 3 Widowed 4 ☐ Divorced Year or Dates: "natural", er than "natura 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ae Health and Mental Elizabeth Kemp is marked Jay Comly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at Important: If item 27 is any injury or other trauons: 6 Caribou Court, Parkton, Maryland 21120 Jeffrey S. Bortel / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Haddonfield, * 4 ☐ Donation 5 ☐ Other (Specify) Haddonfield Bapt. Cem. 11/5/04 Jorsey 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Lin nsee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Plmonge Immediate Cause (Final disease or condition resulting in death) Obstructe **Physician** 2975 /Medical Due to (or as a consequence of) **Examiner** evventi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of Box 68760, physician Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) o the detached 9 Unknown 9 Unknown ል Division of Vital Records, P. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ å 2 🗆 No 3 Probably 4 Unknown 1-KQ Yes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 20 No ate 1 Yes certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes No P 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Piss L 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation (Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 To the F 29b. Signature and title of certifier 29c. License number WI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catursville Maryly (hoio 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2004 Registrar

			1- For State of Maryland / I		rtment of tificate of			~ ~	04	35247	7
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Mary Elizabeth Bloom				2. Date of Death Month	Day	Year 2004	3. Time of Death 6:24 PM	1
1	Examir		4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTS			or Location of Dea	th	4c. County	of Death	RE	
	Funeral Director		01		Months Days			1923	9. Birthpl Count Mary	ace (State or Foreign ry) ' land	n
	the Maryland	JO.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow Maryland n/a Bal	vn or Loca					10	d. Inside City Limits	
	with the I	Director	10e. Street and Number 3500 Mary Avenue	CTIIIO	10f. Zip Code	21214	10	g. Citizen of V	What Count	-	
986	72 hours efter deeth with the Maryland natural', or Items 23a or 28a-f ehow Jical Extendrer mast be inclified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		as Decedent of Yes, specify Cub	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rac	ce - America ck, White, e	n Indian, tc.	
21215-0036	filed within 72 hor Hygiene. other than "nature ent, the Modical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give ki life. D	ent's Usual Occu ind of work done O NOT use retire	ed) during most of wo	orking 1	6b. Kind of Bi			
land 2	d a b	To Be Co	12 yrs. 17. Father's Name (First, Middle, Last) Michael A. McCormick	3611	Linp roy		me (First, Middle, M. T. Par	aiden Suman		ore Owner	_
Maryland	2 4 2 5		19a. Informant's Name/Relationship (Type, Print) Mrs. Susan F. Shine / Daughter 7	Mailing 922	Address (Stree	t and Number or R	ural Route Number, Baltimore	City or Town,	State, Zip (
Baltimore,	Pages 1 a lent of Hea nt: if Item ry or othe		20a. Method of Disposition 20b. Place or cemete.	f Disposi	ition (Name of atory or other pla	ace)		Oc. Location -	City or Tov	n, State	
Balti	permit. Pages 1 Department of F Important: if Ite any injury or ot once.		21. Signature of Funeral Service Licensee Michael E. Canapp	22.	Name and Addr	ess of Facility		5 Harf	ord R		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence CAD	not enter						Approximate nterval Between Onset and Death	
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen		Tus						
P.O. Box 68	requires that the death certificate een signed by the attending phys nould be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Festal death 4 □ Pregnant at time of death 9 □ Unknown		ctopic pregnanc Other (specify)	cy .		23d. Dat Mor	e of delivery	r ay Year	
	w requires that been signed by should be deta	by	Part II. Other significent conditions contributing to death but not resulting in	n the und	lerlying cause gr	ven in Part I.	23e. Did toba 1 ☐ Yes			cause of death?	
Vital Records,	The faw ate has b page 2 sl	Completed					24a. Was an autopsy performe	d?	prior to comp leath?	y findings available pletion of cause of	
Division of Vita	ending Physician: The eath. or: After this certificate the funeral director, pag	Certification; To Be	1 X Natural 5 ☐ Pending (Month, Day Year) [investigation]	Itpatient Time of Injury	28c. Inju Wo	her: 4 \(\text{ Nursing F}\)	ath Check onl. one dome 5 Residence 28d. Describe how	injury occurre	ed		
Divi	sital or Atl ars efter d ral Direct lled in by		4 Homicide determined 28e. Place of Injury - At nome, to building, etc. (Specify)				28f. Location (Stre City or Town,	State)			
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	i, death o d/or inve	stigation, in my	opinion, death occu	urred at the time, date	and place, a	and due to the	ne cause(s)	
	2369	2	29b. Signature and title of certifier MD			S 0000		Date signed		4, 2004	
70	-(1		30. Name and address of person who completed cause of death (Item 23a) (Dr. SANDEEP SHARMA; 9000 FRANK 31. Date filed 7Mm/h, Christophia			E DRIVE,	BALTIMO	RE, M	1D 21	237	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 2004 Sequence B	-	books	<i>j</i>					

Melanie Bredemeier Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-07019 1- State of Maryland / Department of Health and Mental Hyger 1 - State Unpend Item 23a, 27, 28a-f per me CB38 12-2-04 tas

Certificate of Death

Reg. No. RPD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 30, 2004 1105 P M **Melanie** Bredemeier /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 262 Bell Hill Road Elkton Cecil 8. Date of Birth 1980 7. Age (In yrs. last birthday)
24 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Hours Min. Delaware Director 221-62-2788 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show ust be notified at Delaware New Castle 1 Yes 2 No Wilmington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2616 Whitman Drive 19808 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced 'natural' Completed other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Travel 12 Customer Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert E. Bredemeier Pages 1 and 2 should be Linda S. Gumprecht 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shu Department of Health and Important: If item 27 Is m any injury or other traum <u>once.</u> Linda S. Gattuso / Mother 621 Delaware Avenue, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Graceland Memorial * 4 ☐ Donation 5 ☐ Other (Specify) Nov. 4, 2004 Wilmington, DE 21. Signature of Fund. Service Leensee 22. Name and Address of Facility Doherty Funeral Home M01113 3200 Limestone Road, Wilmington, DE 19808 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Methadone Intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed Due to (or as a consequence of): physician a 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de-23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) o the 9 Unknown à ۵ The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence Worther (Specify) At Scene 1X Yes 2 □ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury Found h, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Found 1 ☐ Yes 2 😿 No 10:59 P 2 Accident investigation 10-30-04 10:59 P M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown 6X Could not be determined Director: 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Knights Inn Motel þ 4 Homicide hours after Elkton, Md Found in motel room within 24 hours a 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) UL October 31, 2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 KOREL 22. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 – For Registrar	State of M	larylar		artment <i>tificate</i>			Mental Hy	gien Reg. N	2001.	35249
	0		Decedent's Name (First, Middle, La	ist)						2. Date of De	ath		3. Time of Death
_	Physici /Medi		Jerome Paul Brado	lock						Novemb	er .	3, 2004	7:39 A M
	Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, T	own, or L	ocation of Death			c. County of Death	
			Suburban Hospital					hesd.			M	ontgomery	
	Funeral			Sex 7.A 1⊠M 2□F	.ge (<i>In yr</i> s. 57	last birthday) Yrs.	If Under 1 Months	Days	If Under 24 Hrs. Hours Min.	(Month, Da	th ay, Year	9. Birth	place (State or Foreign ntry)
	Director	ļ	216-50-7644 Usual Residence of Decedent							Jan. I), 1	94/ Wash	ington, DC
	yland now		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mar e-f sh	ctor	Maryland Montgome	ry	Ве	thesda							1 □Yes 2 ☑ No
	death with the Maryland rms 23a or 28e-f show rrest be notified at	Director	10e. Street and Number	_			10f. Zip (Code			10g. C	itizen of What Cou	ntry?
	ath w	ral	8218 Wisconsin Av	·				814				ted State	
	er de Kems	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	J.S. 13.	Was Decede f Yes, specif	nt of His fy Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No o Rican, etc.))-	 Race - Americal Black, White, 	
	J36		1 Never Married 2 Married Married Married Married	1 ☐ Yes 2√2 If Yes, Give Year or Dates:	:		1 ☐ Yes 25	No No	Specify:			Specify: Wh	iite
	5-00 2 hou	Completed by	15. Decedent's E			16a. Dece	lent's Usual	Occupat	ion		16b. l	Kind of Business/In	ndustry
	212 thin 7	ple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	a retired)	iring most of wor	King	Bu	ilding Ma	_
	ed wi ygien ygien t. th	Sol	-	1		Custo	dial H				l	Company	
	the fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Las John Patrick Brad	•				1		ne (First, Middle	, Maide	n Sumame)	
	ryla nould d Mer narke	2	19a. Informant's Name/Relationship			10h Mailie	a Addansa (/C4== = 4 = =		Hurley	Cit.	or Town, State, Ziu	0041
	Ma d 2 si th an th an treur		Michael J. Braddo		er	1						ersburg,	,
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28e-f show any injury or other treumatic event, the Marical Exacting Exacting and once.		20a. Method of Disposition	217, 220011	20b. I	Place of Disco	sition (Name	e of	I	Date		ocation - City or To	
	Pages ent of ht: If i		1 ☑ Burial 2 ☐ Cremation 3 [3 4 ☐ Donation 5 ☐ Other (Special Control of C		9 '	cemetery, crer Gate o		en	Nov. 200		C - 1 1 -	ton Confe	. Manadan
	mit. I partm partm		21. Signature of Funeral Service Line			Ceme	. Name and	Address	of Facility Ro	bert A.	Pum	phrey Fu	g, Marylan neral Home
			Man /	HO!	0689	В	ethesc Bethes	la-Ch sda.	nevy Cha MD 2081	se, Inc	. 75	57 Wisco	nsin Avenu
			23a. Part Enter the disease, or con sheck, or heart allure. List only	plications that cause one cause on each	ed the dear								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardio	opu1m	onary .	Arrest	:					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consec	quence of):							
8	Examiner	<u></u>	Sequentially list conditions,	b. Myocar	rdial	Infar	ction						
0739AM	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (01 0	0 4 0011000	quarisa ary.							
53), execu n and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or a	s a consec	quence of):							
	Records, P.O. Box 68760, The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		_ d								_	
)Ou	68 rtifica	Jedi	IF FEMALE:			12					T		
okh	Box sath cert attendin for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			Ectopic pre	gnancy			1	23d. Date of delive	ery Day Year
	. 0 00	Sici	1 Yes 2 No	4☐Pregnant : 9☐Unknown	at time of o	death 5	Other (spe	cify)				WOITH	Day
1	Vital Records, P.O. sicien: The law requires that the decentificate has been signed by the rector, page 2 should be detached		Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying car	use diver	in Part I	23e. Did t	obacco	use contribute to t	he cause of death?
3	ds,	Completed by	, 	··· -			,	3			Yes 2		pably 4 □Unknown
0	v requestions	lete					_			24a. Was	an	24h Were auto	ansy findings available
77	Vital Rediction: The law	d L								auto perfo	psy ormed?	death?	ppsy findings available impletion of cause of
2		a	25. Was case referred to medical	T			-		26 Place of Dea	1 ☐ Yes ath (Check only o	2 ½ No	o 1 🗆 Yes	2L; No
76	f Vita	To B	examiner? _1 ☐ Yes 2 🔀 No	Hospital:	tient 2	ER/Outpatier	t 3 DOA	Other				6 ☐Other (Specif	(v)
15	vision of Vita Attending Physicien: r death. sector: After this certifica		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury lay Year)	28b. Time of	28	c. Injury a		28d. Describe			
3	eath. or: Af	catic	2 Accident investigation	on			М		es 2□No				
20	Division or Attending after death. Director: After	Certification:	3 Suicide 6 Could not 4 Homicide determined	286. Place of It	njury - At h etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory,	office		28f. Location (City or To		nd Number or Rura 'e)	al Route Number,
A	pitel ours a serel D		Constitute 1977 Constitution I	hydinian. To the hea	at of my lon-	avilada - d4			data and class	and due he she			
\$	Hos 24 ho Fundately f	Medical	29a. Certifier 11X Certifying P (Check only 0ne) 2 Medical Exa	hysician: To the bes miner: On the basis and manners	of examina	owiedge, deati ation and/or in	vestigation, i	t the time in my opi	nion, death occu	rred at the time,	date an	s) and manner as s id place, and due to	tated. o the cause(s)
SAADDOCK, JERRY PAUL	Division of To the Hospitel or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Mec	29b. Signature and title of certific	////	,		29c.	License	number		29d. Da	ate signed (Month,	Day, Year)
	⊢ s ⊢ ō		· Ca	Met /	M	(1)	D6	0887			Nov	ember 4,	2004
	10		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type,					V	CMDCI 79	_00.T
	V		Jack L. Flyer, M	.D. 5330 W	lisco	nsin Av	enue,	#75	0, Chevy	y Chase.	_Ma	ryland 20	0815
11		ate	31. Date filed (Month, Day, Yeer)	32. Regis	trar's Sign	ature		1000					
`	Regist	rar	NOV 0 0	2004	75mello	-as	1 1	11Ba A	al				

			1 - State of State of Registrar		epartment of He			ene 2004	35250
			Decedent's Name (First, Middle, Last)				. Date of Death Month	5. 10.	3. Time of Death
	Physici /Medic		Francis Bernard Bri	Snick			lovenbe	Day Year	3:25 PM
1	Examin	er	4a. Facility Name (If not institution, give street and number 1)		4b. City, Town, or f			4c. County of Dea	th
	Farmer		Harbor Hospital Center	Age (In yrs. last birtho		ore If Under 24 Hrs. 8	. Date of Birth	9 Bir	tholace (State or Foreign
	Funeral Director		222 22 24 1₹M 2□F	81 Yr	Months Dave	Hours Min.	(Month, Day, 3-07-19		thplace (State or Foreign puntry)
	pur		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	Maryla	ō	MD	Baltimo					1 Yes 2 □ No
	r 28a	lrec	10e. Street and Number		10f. Zip Code			g. Citizen of What C	ountry?
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Estaninet must be notified at	Funeral Director	1931 Griffis Ave		21230		U	.S.A.	
	er des items cer m	nue	Armed Ford	ent Ever in U.S. es?	 Was Decedent of His If Yes, specify Cuban 	panic Origin? (Specif , Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ami Black, Whi	
336	urs aft	þ	1 Never Married 2 Married 1 yes 2 If Yes, Give Year or Dat		1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh:	ite
21215-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occupat	tion uring most of working	1	6b. Kind of Business	/Industry
121	filed within Hygiene. Ithar than "	mpl	Elementary/Secondary (0-12) College (1-4	for 5+)	Give kind of work done du ife. DO NOT use retired)				
d 2	filed withir Hygiene. othar than ant, tre M		17. Father's Name (First, Middle, Last)	Del	livery Drive	er 18. Mother's Name (F		Ice House	
lan	Mental Mental arkad o	To Be	Joseph Bresnick			Florence S	Schmidt		
Maryland	shd and is m		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street ar				Zip Code)
	1 and 2 Health am 27		Paul Bresnick, Brother 20a. Method of Disposition		B1 Griffis A			21230 Oc. Location - City or	Town State
nor	ages of of the tr. Witte		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from St	a.0	isposition (Name of crematory or other place				
altimore,	permit. Pages 'Department of Himportant: If its any injury or of once.	1	21. Signature of Funeral Service Insee	Bayview	Crematory Name and Address Ambrose Fun	11-08-2 s of Facility		Baltimore	, Ma
ä	Dep Impe	1	Jul Chamathal	PHIL	2719 Hammor	nds Ferry	or Lan Rd.Lans	downe, MD	21227
			23a. Part1. Enter the disease, or complications that cal shock, or heart failure. List only one cause on each	used the death. Do not ch line.	t enter the mode of dying	, such as cardiac or re	espiratory arres	st,	Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	respirator	y failure				624 hours
	Examiner		- 0.011	r as a consequence of))				Law Mr.
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Universiting Cause (Disease or injury		1/19/35				
	ecuted and -transi	Examine	that initiated events	r as a consequence of)	illation				4 days
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d -4 U		Laren Mai	of left	arotal	alad	months
9	tificate g phys	Physician/Medical		2				1000	
Вох	eath certific attending pl	an/N		ome of pregnancy th 2 Petal death	3 ☐Ectopic pregnancy			23d. Date of de Month	livery Day Year
.O.	he dea the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	nt at time of death in	5 Other (specify)			Wionin	Day rear
4	es that the de igned by the a be detached t		Part II. Other significant conditions contributing to dea	th but not resulting in th	he underlying cause giver	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	w requires been sign should be	ed by					1 Nes	2 □ No 3 □ Pi	robably 4 Unknown
ecords,	e law requ has been je 2 shouli	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
H		Соп					perform	ed? death? □ 1 □ Yes	
Vita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	patient 2 ER/Outp	Other	26. Place of Death (C			
of	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of		ne of 28c. Injury	at 280		ce 6 □Other (Spe vinjury occurred	city)
sior	uttandin death. ctor: Aft y the fur	atio	2 Accident investigation	Day reary mije		es 2 🗆 No			
Division	l or Attano after death Diractor:	Certification;	determined 200. Flace U	f Injury - At home, farm g, etc. (Specify)	, street, factory, office	28f	. Location (Stre City or Town,	eet and Number or Re State)	ural Route Number.
	A Hospital 24 hours a Funeral etely filled		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge, o	death occurred at the time	e, date and place, and	d due to the cau	ise(s) and manner as	s stated.
		Medical	(Check only 2 ☐ Medical Examiner: On the bas one) and manne	is of examination and/	or investigation, in my opi	nion, death occurred	at the time, dat	e and place, and due	to the cause(s)
	To the within To the Comple	2	29b. Signature and title of certifier		29c. License			d. Date signed <i>(Mont</i>	
	'n		30. Name and address of person who completed cause	D 10+0	In AS 249	41614-821		ovember	4 2004
	'd		Lisa Wonzel	kybor Hrs	soital Center	3001 Sou	th Har	maryla	4 2004 nd 21225 = Baltimore City
	Sta	_	UIT . A	gistrar's Signature			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		7
	Registi	rar	NOV 0 8 2004	eneva /	9 land				

State of Maryland / Department of Health and Mental Hygien 004 35251 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Betty Bachura November 2, 2004 7:20 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery General Hospital Montgomery 8. Date of Birth (Month, Day, Year Sent. 26, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Min. 1 □ M 2 🕅 F New York 089-18-3955 Yrs. Director 1910 94 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event. It a Medical Examination trust by motified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14400 Homecrest Road 20906 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Flynn Mary Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum <u>once.</u> William Adams (Son) 8087 Bark Ct., Murrells Inlet, SC 29676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cemetery 1/6/04 Johnson City, NY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Allen Memorial Home, Inc Mamon 511-513 E. Main St., Endicott, NY 13760 Lennis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBRU VASCULAR ACCIDENT Immediate Cause (Final Physician disease or conditior resulting in death) /Medical Examiner CANCER COLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the attending physician and thed for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Phospital or Attending Pl 24 hours after death. Funeral Director: After the 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier Greenway Center Drive Suite 207 Greenbelt, Marylan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lamesh Patel 7525 32. Registrar's Signature NOV 0 8 2004 Registrar

		1- State of Marylan Registrar State of Marylan per Dr., G837,	11705 11705	partment of Ho Childhb ertificate of L	ealth and Me Death	ntal Hygier	2004	35252
Physic	cian	Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day Year	3. Time of Death
/Med		William Br	randt			Octobe	r 29, 2004	8:00p ^M
Exam	iner	4a. Facility Name (If not institution, give street and number)	Location of Death	TII: 11 O'1				
Funera		4678Woodland Rd. 5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday	y) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	9. Birt	loward thplace (State or Foreign
Directo		481.28.4865 1 X 2 □ F Si	Yrs.	Months Days	Hours Min.	(Month, Day, Yea vember 18.	ar) Co	untry) Harpe,Illinois
pu. ≥		Usual Residence of Decedent	y, Town or i	ogation	TVC	Veniber 10,	1022 - La	10d. Inside City Limits
Aaryla Fahov	5		y, rown or a		0.11			1 ☐ Yes 2√☐ No
ith the Marylan or 28a-f ahow	Director	Maryland Howard 10e. Street and Number		10f, Zip Code	cott City	10g. (Citizen of What Co	buntry?
h with		4676 Woodland Road			21042		U.S	§A.
If a large of the manyland filed within 72 hours after death with the Maryland Hygiene. that than "natural", or items 23a or 28a-f show int, the Mariest Evanther must be natified.	Funerai	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	.S. 13	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Speci	fy Yes or No-	14. Race - Ame Black, White	erican Indian,
or its	by Fu	1 Never Married 2 Married 1 Yes 2 No	942	1 ☐ Yes 2 ☒No	Specify:	,	Specify:	White
tural'	q pa	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	953 16a Dec	edent's Usual Occupa	tion	16b	Kind of Business/	
nin 72 nin 72	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Giv	e kind of work done d DO NOT use retired)	uring most of working	135.		ilding
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be file	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name (i	First, Middle, Maid	en Sumame)	
should and Men marks	ုင	Henry Leonard Brandt	101 11			-	n Bradshaw	
Mand d 2 st th and 17 ts n traun		19a. Informant's Name/Relationship (Type, Print)		iling Address <i>(Street</i> a 4676 Woodland				up Code)
Deficiency (Mary) and posterior 212.1370030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avant, it a Mariest Examination must be notified.		Edd. Middied of Biopodition	Place of Disp	position (Name of	Dat		Location - City or	Town, State
mit. Pages partment of portant: If it y injury or o		1 Burial 2 Cremation 3 Removal from State		ematory`or other place m.Chapel Cem	11/02	/2004	Clarks	ville, MD
Dailt. permit. Departm Imports any inju	ġ	21. Signatura of uneral Service Liber see		22. Name and Address				
0 88E 88	8	MULOQUIX When MOISY	13	Slack F	uneral Home, F	P.A. ce Ellicott Cit	v MD 21049	
		23a. Part1. Enter the disease or complications that caused the death shock, or heart failure. Ust only one cause on each line.	h. Do not e	nter the mode of dying	, such as cardiac or r	espiratory arrest,	,, WID 21040	Approximate Interval Between Onset and Death
Pnysiciar /Medica	_	Immediate Cause (Final disease or condition resulting in death)	Schen		many lasco	lar Misea	se	3 Months
Examine		Due to (or as a consequ	uence of):		,			
Page 1	je l	Sequentially list conditions if any, leading to immediate b. Due to (or as a consequence of the conditions)	uence ot):		-			
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DC, be exe cian a nurial-l	Ě	resulting in death) Last Due to (or as a consequence)	uence of):					
ficate be executed physician and is the burial-transit	edicai	d						
	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna					23d. Date of deli	ivery
The law requires that the death certiful to the law requires that the death certiful to the asset of the asse	hvsician/M	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
by the								
es tha	by P	Part II. Other significant conditions contributing to death but not resi	ulting in the	underlying cause give	n in Part I.			the cause of death?
law requires as been sign 2 should be	ted						2 No 3 Pr	obably 4 DUnknown
e law has t	Completed					24a. Was an autopsy performed/s	24b. Were au prior to death?	completion of cause of
VICIAN: The ician: The sector, page	e Co	25. Was case referred to medical			00 00	1 □ Yes 2 🔀 1		2 No
ysicia s certi	0	examinar? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatio	ent 3 DOA Othe	26. Place of Death (6	1/	6 ∏Other (Spec	cify)
ng Phy ter this	i i	27. Manner of Death 28a. Date of Injury	28b. Time Injury	of 28c. Injury	at 28	d. Describe how in		,
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lor Atter after dea Director in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specific process)	ome, farm, s by)	street, factory, office	28	Location (Street City or Town, Sta		ural Route Number,
pital ours a eral (C	29a. Certifier 12 Certifying Physicien: To the best of my kno	wledge dea	ath occurred at the time	e date and place and	d due to the cause	(s) and manner as	stated
To the Hospital or Attending Physician: The law within 24 hours after death. To the Fuileral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medicel Exeminer: On the basis of examina and manner stated.	ition and/or i	investigation, in my op	inion, death occurred	at the time, date a	ind place, and due	to the cause(s)
To th withir To th comp	ž	29b. Signature and title of certifier		29c. License	number	29d. [Date signed (Month	n, Day, Year)
		Men Mellen M.J.		23	4613	00	Nober 29	, 2004
		30. Name and address of person who completed cause of death (Item	n 23a) (Type	Print) Annuly	la Rel 8	Ellicator (Ju Mo	21042
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature	,		- Partial I	7	- 11 - 1
Regis	strar	NOV 0 8 2004 Sever &	de	outs				

State of Maryland / Department of Health and Mental Hygie 20 0 4 35253 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year CARROLL 0310 AM DOROTHY 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON TOWSON MANOR CARE RALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Jan. 22, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-20-9483 1 □ M 2 □ F 86 Maryland Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "natural, or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified = 9058. 10c. City, Town or Location Fallston 10a, State 10b. County 10d. Inside City Limits Maryland Harford 1 ☐ Yes X☐ No Direct 10e. Street and Number 10f. Zip Code 21047 10g. Citizen of What Country? 624 Reckord Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. | ☐ Yes 2 ☑ No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Spellack 1 ☐ Yes 2X No Specify ρ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Years Nurse Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Etta Quigley James Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Reckord Rd Fallston, Maryland 21047 Joyce Caldwell/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Please) 11/54 04 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licensee 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** GANGRENE RIGHT GREAT TOE resulting in death) /Medical Due to (or as a consequence of): Examiner PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-transit HYPERTENGE N HTN Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical COPD IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed need MPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page this certificate OSTEOARTHRITIS 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☑ No М To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A nla nla 2 Accident nla 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide n/a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -, DO nel 04 H0061312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7445 E FURNACE BRANCH RD, GLEN BURNIE, MD 21060 SHAH PURVI D.O. 31. Date filed (Month, Day, Year) 32. Registrar Signature State NOV 0 8 2004 b Registrar

State of Maryland / Department of Health and Mental Hygiene 35254 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth **Physician** -nri 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Himoke n/a tenesis Eldercare ona thean If Under 24 Hrs. 8. Date of Birth May 22, 1920 5. Social Security Number 216-01-7889 Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland 6. Sex **Funeral** Months Days 1 M 2 □ F 84 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryle Depertment of Heelih end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 shown with injury or other traumatic event, the Medical Examiner must be notified at page. MD n/a Baltimore 1X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 115 East Melrose Avenue 21212 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Merital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Police Officer City of Baltimore 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Coyne Katie Weber 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellen Coyne Cooke-daughter 9325 Ramblebrook Road, Baltimore, MD 21236 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Cemetery 11/9/04 Fullerton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Leonard J, Ruck, Inc. Funeral Home 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final diseese or condition resulting in death) Atheroscleratic (CC)10 VCSU10 Examiner unknown Due to (or as a consequence of): Examiner Unknown Fibrilletic or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Un Known Hypertensian Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probabty 4 Unknown 1 T Yes 2 No Hypuchal estrelenia ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy Dementia. 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral of 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) 11/6/04. D0059056 MD 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 31. Date filed (Month, Day, Year) Royal SYL J. M B=1+ MD 21217 1660 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
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Reg. No. 1- State of Maryland / Department of Health and Mental Hygiene
Reg. No. 1- State of Maryland / Department of Health and Mental Hygiene
Reg. No. 1- State of Maryland / Department of Health and Mental Hygiene Reg. No U U Ls nt's Name (First, Middle, Last, 2. Date of Death October **Physician** opel an D 2004 11:32 A M OWART /Medical 4a. Facility Name (If not institution, give street as 4b. City, Town, or Location of Death 4c. County of Death **Examiner** rles Village Future 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Days Months 1**№**M 2□F Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits works 7 is markad other than "natural", or Itams 23a or 28a-f shov traumatic avant, the Madical Examinar must be notified all 1 Yes 2 □ No Director nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black, White, etc. hours after 2 □ No 1 Never Married Married Maryland 21215-0036 1 Yes 2 No Specify blas ģ 3 □ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 an Secondary (0-12) College (1-4or 5+) Hygiene. 17. Father 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sun 2 should be fi and Mental h Be 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, of Health itam 27 othar t Method of Disposition 140 Baltimore, 20c. Location - City or Town, Pages 1 Burial Cremation 3 Removal from State = 5 Department of Important: If any injury or once. 5 ☐ Other (Specify) ¹ 4 □ Donation 104 21. Signature of Funeral Service Licensee W Em Piko MD21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) pheumonia Physician /Medical Due to (or as a consequence of): Terminal Aspiration Examiner ATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): death certificate be executed burial-transit Vascular Accepent Exami Cerubral Due to (or as a consequence of) physician a Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9□ Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES mELLITUS Hy pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s has autopsy performed? 2130 rder Seizure certificate 2 □ No of Vital 1 Yes 2 No 1 TYes Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner Hospital: Other: P 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division After Hospital or Attanding 1 Natural 5 Pending Injury death. 2 🗆 No investigation 1 Tyes 2 Accident within 24 hours after death To the Funaral Director: . completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) mg

State Registrar 31. Date filed (Month, Day, Year) NOV 0 8 2004

Don

Name and addr

04 Tunbri 32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lorraine October 18, 2004 Kathryn Calzaretto 6:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Annapolitan Nursing Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 86 Vrs 338-03-6293 Director July 1918 Illinois Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, The Maxical Examinations the natified at 1 ☐ Yes 2 ₹ No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 North Old Mill Bottom Road 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after uand Mental Hygiene. Is marked other then "neturel; or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Š Specify: Specify. 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Simon H. Faupel Mary M. Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n any injury or other treun once. Judith Willingham - Daughter P.O. Box 165 Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 10-23-04 * 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Park, IL 21. Signature of Funeral Service Licen Heeney Funeral Home 2929 West 87th St. Evergreen Park, JL 60805 part). Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician CORONARY ARTERY disease or condition resulting in death) many years /Medical Due to (or as a consequence of): Examiner Hypatension many years Sequentially list conditions, Teny leading to make a cause. Enter Underlying Cause (Disease or injury Due to for as Examiner certificate be executed use as the burial-transit chronic obstrution many years heimanuty discuss that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗆 Yes 1 Tyes Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify Assisted 2 📈 No ပို 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Living After after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funerel D completely filled i 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dr. llean MO D40519 10.31.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRZA M. NUSCICAL 1667, Cropton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiena 35257 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 7:35 P.M MERCEDES M. DOHERTY NOVEMBER /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE 8137 LOCH RAVEN BLVD. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 217-20-1895 Director 2/17/1925 MARYLAND Usual Residence of Decedent deeth with the Maryland 10a State 10b County 10c. City, Town or Location show 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov Injury or other traumatic event, the Nedical Examinar must be notified at MD BALTIMORE TOWSON Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8137 LOCH RAVEN BLVD. 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð Specify: WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 h nent of Health and Mental Hygiene. int: If Item 27 is marked other than "natu 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TELEPHONE OPERATOR PHONE COMPANY 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES MCCABE MARTHA MCGROGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN DOHERTY SON 2429 MARYLAND AVENUE BALTIMORE, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 11/8/2004 BALTIMORE. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer Metastation LV19 MOS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): led by the attending physician detached for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 16 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 X No Yes after death.

Director: After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Cther: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1. Natural 5 Pending investigation 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital or within 24 hours at To the Funeral D 1 [L/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ldaepo H40583 Ú1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stelly Bel Air Ma 21015 Inddore ,00 Stephin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 8 2004

			1 - State of Maryland / Department of Certificate of Registrar		Al Hygiene 004	35258
	Div. of the		Decedent's Name (First, Middle, Last)	2. Dai	e of Death nth Day Yea	3. Time of Death
	Physici /Medic		Mildred Dorothy Dorsey		ober 30 200	
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town	n, or Location of Death	4c. County of D	eath
			Greater Baltimore Medical Center Tows		Balti	
	Funeral		$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	ys Hours Min. (Mo	e of Birth 9.1 onth, Day, Year)	Birthplace (State or Foreign Country)
	Director		219-60-9602 1 M 2 A F 94 Yrs. World Decedent	Mar	ch 8, 1910	Maryland
	land 1		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
_	Mary f sh	o	Maryland Baltimore Co. Timonium			1 ☐ Yes XX No
_	28a	rec	10e. Street and Number 10f. Zip Cod	9	10g. Citizen of What	Country?
	3a o	D	2300 Dulaney Valley Road	21093	United	States
•	deat	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Specify Ye uban, Mexican, Puerto Rican,		merican Indian,
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21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f show he Medical Estantrar must be ricitlised at	d by	3 AWidowed 4 ∐Divorced Year or Dates:		Specify:	inite
7	nat nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work do life. DO NOT use re:	ne during most of working	16b. Kind of Busine	ss/Industry
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an	d ba ental cod c	To Be	George Dressel	Mattie M	owbray	
Maryland	should and Men marke umatic	ř		eet and Number or Rural Route		e, Zip Code)
N	nd 2 Ifth au 27 is r trau		Mr. Frederick Dorsey, Jr./Son 237 Mariner	s Point Drive	Baltimore, M	D 21220
ē,	s 1 a of Hea item othe		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City	
E	Page nent c nt: If rry or		1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other (Parkwood Cemete		04 Baltimor	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Exertiner must be notified 24 once.		21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Ad	dress of Facility	5305 Harfo	
B	89 = 28			J. Ruck, Inc.	Baltimore,	MD 21214
п			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each ling.	tying, such as cardiac or respir	atory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	lation		Onset and Death
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	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	calE	L _d			
89	ificate g phy as the		u.			
Box	leath certifica attending phy I for use as th	M/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
	death	by Physician/Med	in the past 12 months? 1 Ves 2 1		Month	Day Year
P.O.	at the by th	hys	9 LJ Onknown i			
	res that the de signed by the a be detachad f	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 23	e. Did tobacco use contribute	. /
ord	w require been si should b	ted	almenta		1 Yes 2 No 3	Probably Unknown
Records,	law las b	Completed		24	autopsy prior t	autopsy findings available o completion of cause of
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Vital	Iclen Sertifi ector	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)	
of	Physicien: this certificatal director, I	٦.	1 Inpatient 2 EN/Outpatient 3 DOA	4 Nursing Home 5	☐ Residence 6 ☐ Other (Sinscribe how injury occurred	pecify)
uc	Jing After fune	tion	i adirection of the second	njury at 28d. De Vork? □ Yes 2 □ No	scribe flow injury occurred	
Division	Attendii death. ctor: A y the fu	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, offin		ation (Street and Number or	Rural Route Number.
Div	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City	or Town, State)	
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attengent filled in by the fune	alc	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the	time, date and place, and due	to the cause(s) and manner	as stated.
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated.	y opinion, death occurred at th	e time, date and place, and d	ue to the cause(s)
	Within To the To	ž		ense number	29d. Date signed (Mo	nth, Day, Year)
•	1/1		Virtuez alle aures	39099	11-2-	04
Î	11		30. Name a d address of pe son who completed cause of death (Item 23a) (Type, Print)			
	\		Rodney Williams, M.D. 6701 N. Charles S	t. Towson, Mar	ryland 21204	
	Sta		L 31 Date filed (Month - Day, Year) L 32 Registrar's Signature		, ,	
	Registr	ar	NOV 0 8 2004 here & Spark	/		

State of Maryland / Department of Health and Mental Hygien 35259 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4 **Physician** Lillian Emery 2004 November 12:20 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore St. Martins Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 23, 1909 Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days Hours 95 213-03-1442 Yrs Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland Baltimore Catonsville 1 ☐ Yes 2 🕅 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examples 2008. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc 1X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Merchant Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha E. (Unknown) Allan Emery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Butterhoff / Niece 4106 Chardel Apt. G, White Marsh, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 11/6/2004 Baltimore, Maryland Holy Redeemer Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur o Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, of complications shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician Due to or a a consequence of): disease or condition resulting in death) ONARY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à TENSIVE CARDIOVASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? YRODISM cate has autopsy performed? STAGE DEMENTIA 1 🗌 Yes Yes 2 No Division of Vital the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: , 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after within 24 hours at To the Funeral D 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anal D18365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 308. Balto. 3455, Wilkens K. Dang M.D. 31. Date filed (Month, 32. Registrar's Signature NOV 0 8 2004 Registrar

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar 35261 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** SYDREATA M. EADES 1.38 PM Vovember 2, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Sinai Hospital of Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 😾 F 219-86-0739 MD 33 Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "naturel", or itams 23e or 28a-f ehow any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5303 BELLEVILLE AVENUE 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME REMODELER 10 RESTORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RENEE MOORE JAMES A. GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES A. GREEN/FATHER 2021 W. BALTIMORE ST., BALTIMORE, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 11/08/2004 BALTO., MD MT. ZION 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES $\,$ A. $\,$ MORTON $\,$ & SONS $\,$ F.H., $\,$ INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AIDS /Medical Due to (or as a consequence of) **Examiner** End Viseade Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) anding physicien and use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐Yes 2 ☐ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2FINO To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie November 2,2004 ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Fatto Hospital of Baltimore Suzan 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Patient Known as Sydreata Eades

	1. Decedent's Name (First, Middle, Last) Icon Dhilippo Doul	2. Date of Dea	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Jean Philippe Paul Jean Philippe Estrada-Paul	Novemb	per ^{pa} 4, 2004 2037P. M
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, o	r Location of Death	4c. County of Death
	6099 Majors Lane # 9 Columbi		Howard
Funeral Director	224-95-8808 1XI M 2 F 28 Yrs. Months Days	Hours Min. (Month, Da.	h y, Year) 9. Birthplace (State or Foreig Country) 4. 1976 Haiti
yland	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
with the Mar s or 28e-1 s be notified Director	Maryland Howard Columbia		1 ☐ Yes 2K No
or 28	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
s 23a	6099 Majors Lane # 9 21045		Haiti
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "netural", or Items 23a or 28e-1 show any injury or other treumatic event, It a Modical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. If Yes, specify Cuba If Yes, Specify Cuba If Yes, Give Year or Dates:	dispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: Haitian
Definition of the property of	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done life. DO NOT use retires.	pation	16b. Kind of Business/Industry
ed within 72 horygiene. ner than "neturalit. It is Medical E.	Elementary/Secondary (0-12) College (1-4or 5+) 8 Physician	d)	Hoolth Comp
Hygid Hygid Sther		18. Mother's Name (First, Middle,	Health Care Maiden Sumame)
Mental H Mental H arked oil atic even	Reginald Paul	Angela Estrad	a
shou and M e mar umat		and Number or Rural Route Number	
and 2 salth a	Tania Eleanor Brunn (Spouse) 6099 Majors La	ane # 9, Columbia	a, MD 21045
f item	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Date	20c. Location - City or Town, State
Pag ment ent: I ury o	`4 □ Donation 5 □ Other (Specify) Metropolitan Crema:	tory 11/07/2004	Alexandria, Virginia
permit. Depart Import any in		ss of Facility Jefferson ewellan Dr. Alexa	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.	ng, such as cardiac or respiratory ar	rest, Approximate Interval Between
Pnysician	Immediate Cause (Final disease or condition Complications of Diabetes M		Onset and Death
/Medical	resulting in death) Due to (or as a consequence of):	KIIICUD	
Examiner	Sequentially list conditions.		
in sit	Sequentially list conditions, if any, leading to immediate cause [Test in Jury] Cause (Disease or injury		
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tificating phy as the			
The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit completed by Physiciar/Medical Examit	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 2 □ Use 1 □ No 2 □ Use 2 □ No 3 □ Use 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown	/	23d. Date of delivery Month Day Year
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n requires that the de been signed by the should be detached letted by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giv		obacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 □Unknown
siclen: The law requires the centificate has been signed rector, page 2 should be completed by		24a. Was autop perfor	sy prior to completion of cause of death?
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i or Attending Physiclen: after death. Director: After this certific J in by the funeral director, ertification: To Be (27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Wor M 1	y at 28d. Describe h k? Yes 2 □ No	low injury occurred
tel or Attending Prater death. el Director: After ed in by the funer? Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Rural Route Number, in, State)
To the Hospitel or Attending Phyewithin 24 hours after death. To the Funerel Director; After this completely filled in by the funeral di Medical Certification; To	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	ne, date and place, and due to the opinion, death occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
ithin o the omple omple	29b. Signature and title of certifier 29c. Licens	e number 2	29d. Date signed (Month, Day, Year)
F S F O	O.C.I	M.E.	November 5, 2004
1	111 D	enn Street. Balt	imore. Maryland 21201
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1111 Po	emi beleet, bare	more, rary and draw

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			For State Registrar	State of Mar	yland / Dep		f Health and	-	77.7	jible.	0=000
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п		4	Veteranis Nur	cina Ho	me	Bal	timore	_	٨	1117	
H	Funeral Director		5. Social Security Number 6. Sex	7. Age	In yrs. last birthday 85 Yrs.	Months Da		. (Month, L	Sirth Day, Year)	9. Birth	place (State or Foreig intry) WY ANK
	pu .		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or L	ocation				T	10d. Inside City Limits
	Aanyli F sho	ō	MD NA		Baltu		Cita				1 Yes 2 □ No
	28a-	Director	10e. Street and Number		1000	10f. Zip Cod			10g. Citizen o	f What Cou	intry?
	death with the Maryland rms 23a or 28a-f show	I D	2535 Quan	tico Av	e	2	1215			U.S.	A.
	death	Funeral	11. Marital Status	2. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or N	No- 14. R	ace - Amer	ican Indian,
036	be filed within 72 hours after death with the Marylar stat Hygiene. and other than "naturel", or Items 23a or 28a-f show of other than "naturel", or Items 23a or 28a-f show event, the Marifest Extratrict intelliged at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 Yes 25		no nican, etc.)	Spec		ack
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 le marked any injury or other traumatic ex once.		21. Signature of Funeral Service License	96	Gentisa	22. Name and Ac	dress of Facility	10,01	13000	priore	VILD
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0	ng Ph ter th neral	:uc	27. Manner of Death 1 分Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	of 28c. I	Injury at Work?	28d. Describe	e how injury occi	urred	
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	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Exemi	sicien: To the best of ner: On the basis of e and manner state	xamination and/or i	ath occurred at the nvestigation, in r	ne time, date and place my opinion, death occ	ce, and due to the	e cause(s) and r e, date and place	manner as	stated. to the cause(s)
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2	Un	1	30. Name and address of person who co			, Print)	7	^	2 ,	Ø	
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	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	ports					

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	/Medic Examir		4a. Facility Name (I not institution, give :	treet and number)		4b. City, Town, o	r Location of	Death	4c. County	of Death	1001
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	Mary -1 sho	ō	MaryTand n/a		Baltimore					l	1 X Yes 2 No
	h the	Director	10e. Street and Number		-l	10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
	23a c	alD	4605 Powell Avenue			21206			USA		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural; or items 23e or 28e-f show or other traumatic event, the Medical Exam and must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	an, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	Black	- Amend k, White, Whit	
5-0	72 ho	eted	15. Decedent's Edu	cation completed)	16a. Dece	dent's Usual Occup	ation	of working	16b. Kind of Bu	siness/Inc	dustry
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an	ld be ental ked o	To Be		iffin			Rose	Marie	Plahs	2)	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, in M	-	19a. Informant's Name/Relationship (Ty		19b. Mail	ng Address (Street		or Rural Route Numbe		State, Zip	Code)
	1 and 2 Health a em 27 ls ther trai		A. Dean Stocksdale-Att	orney	5 H	emlock Cour	t, Cocke	eysville, Mar	yland 210	030	
Baltimore,	Pale		20a. Method of Disposition 1	emoval from State		osition (Name of matory or other place vice Corpo	' I	Date 11/8/04	20c. Location - (wn, State
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	WITTIAN	5	305 Harford	Rd., Ba	Leonard J. R altimore, MD	21214	Funer	al Home
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause le cause on each l	d the death. Do not en ne.	ter the mode of dyin	g, such as ca	ardiac or respiratory ar	rest,		Approximate Interval Between
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9	ding b	/Med	IF FEMALE:	3c. If yes, outcome	of pregnancy					1	
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year
Vital Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.			bute to th	e cause of death?
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Θ	in Life	Certification;	4 Homicide determined	building, et	ury - At home, farm, st c. (Specify)	201, 100101), 011100		City or Town	n, State)		1.0010 / 10/1/201,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	icien: To the best ier: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the tin vestigation, in my o	ne, date and p pinion, death	place, and due to the coccurred at the time, d	ause(s) and man late and place, ar	ner as stand due to	ated. the cause(s)
	Within To the Comp	N N	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signed	(Month, L	Day, Year)
1	15		> Killed theory	Con		D19	667		11-06-	2004	,
(2'('		30. Name and address of person who co	RTZ, M	D. 7310	Print) RATCHIE	HWY	SUME SOR	URNIE, 1	nD	21061
	Sta Registr		31. Date filed (Month, Day, Year)	72. Registr	ar's Signature	aparks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10 compara the 1837 th 2837 th 222 to 4 and Montal Hydrians

			Amend itemate of the State Registrar	Ce	rtificate	e of L	Death		. Since in ity	Reg. No.	004	35265
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
	Physici /Medio		Raymond fronkows	Ki					NOUZM	ber c	4,2004	7:45A M
}	Examir		4a. Facility Name (If not institution, give street and number)		1 1		Location				unty of Death	
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birti (Month, Day	h v, Ye <i>ar)</i>	9. Birthi	place (State or Foreign ntry)
200	Director		212-18-8969 82 Usual Residence of Decedent	113.	J J				Nov. 25	,1921	Mary	yland
	/land		10a. State 10b. County 10c. City, T	own or Le	ocation						1	l 0d. Inside City Limits
:	Man	tor	Maryland N/A			Ba l t	imor	e Ci	ty			1 X Yes 2 ☐ No
	or 28g	Director	10e. Street and Number		10f. Zip	Code				10g. Citizen	of What Cour	ntry?
	23a		467 Mary Avenue				212	14		Unit	ted Sta	tes
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	ean Indian,
0	or II	by Fu	1 Never Married 2 Married 1X Yes 2 No If Yes, Give WWII		1 ☐ Yes 2		Specify:		,,	- 1		ite
3 .	tural'	pa pa	Carolina Carolina	Fa Dago	dent's Usua	I Occupa	tion					
2	n "na	Completed	(Specify only highest grade completed)	(Give	kind of wor DO NOT us	k done a	lurina mos	t of worki	ng	160. King (of Business/In	austry
Maryland 21215-0036	r tha	mo	Elementary/Secondary (0·12) College (1·4or 5+) 8 Years	Cra	aftsma	n				Manı	ıfactur	ing
2	othe othe	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle.			
	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If them 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, It a Medical Exacting ritual trainfied at ances.	To E	Anthony Fronckowski				So	fie	Rojka			
ָם מ	z should and Men le marke sumatic	0 3	19a. Informant's Name/Relationship (Type, Print)Brother						l Route Numbe			
	and lealth m 27						e Pa		na, Mary		21122	
	rages 1 nent of H int: If iter iry or oth		1X Burial 2 ☐ Cremation 3 ☐ Removal from State	atery, cre	osition (Nam matory or ot	her place	· 1		ate		on - City or To	
	tmen tant: sjury				d Ceme		- 1	/8/20				Maryland
baltimore,	permit. Pages Department of I Important: If ite any injury or of		2 Signature of Funeral Service Licensee	I I	2. Name and Duda-R	d Addres	s of Facilit Fune:	ral 1	Home of	Dunda	alk, Ind	.
			23a. Pan1. Enter the disease, or complications that caused the death. D	7	922 W	se i	Ave.	Dun	dalk, M	aryla	nd 212	
			snock, or heart failure. List only one cause on each line.							est,		Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	Gu,	al	Ar.	Tur					
	xaminer		Due to (or as a consequence	ce of):	1.10	0	.		u1'0			
ar Qa		er	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	ce of):	MICIN	1	MASI	200	NI.O		-	
3	d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events									
Ś	an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence	ce of):								
0000	The law requires that the beauticentificate be executed. The has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	dlcal	d									
0	anding pluse as t	Med	IF FEMALE:			Scat-						
ל ה ה	attending p	an	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dec		Ectopic pre					23d.	Date of delive Month	ny Day Year
5	the ched	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5	Other (spe	ecity)				ļ		
Ĺ	ed by detail	'Ph	Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use o	contribute to th	e cause of death?
necords,	been signed by the should be detached	Completed by Physician/Me	Dementra. (d. 11 101,1	11					1 🗆 Y	es 2 □ Ñ	o 3 □ Prob	ably 4 Unknown
5	beer shou	lete	Diobely, temathy no	· d.	(-			24a. Was a	n 24	th Were autor	osy findings available
ב ב	e has	шо	2 20 3 1 , Fight 200 100	1641					autops	med?	prior to cor death?	npletion of cause of
		Be C	25. Was case referred to medical				26 Place	of Death	1 ☐ Yes :	2 1 No	1 🗆 Yes	2□ N 0
- 3	yard is cer direct	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Outpatier	nt 3 DO	Othe			ne 5 Reside		Other (Snecifi	,)
	h. After this funeral di	n: T		. Time of	f 28	lc. Injury Work			8d. Describe ho			,
5	death. ctor: Af y the fu	atlc	2 Accident investigation	,,	М		es 2 🗆 l	No				
Ž	after death Director: / d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory,	office		2	8f. Location (St City or Town	reet and Nu	mber or Rura	Route Number,
ב ב	urs af oral D			_								
1	Fune Fune stely f	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	lge, deati and/or in	h occurred a vestigation,	it the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the cand at the time, d	ause(s) and ate and plac	manner as store, and due to	ated. the cause(s)
4	within 24 hours after death, To the Funeral Directors After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier		29c.	License	number		2	9d. Date sid	gned (Month, I	Day, Year)
۲	->-0		1 (M)		1)	hor	20	3	11-	امر <u>.</u> ـ ر	,
í	~		30. Name and address of person whill completed cause of death (Item 23)	a) (Type	1-0		00,2	7	1	111111111111111111111111111111111111111		(
N	118		Vilay R. Heads, MD, BRIN	8420	seus St		Her	30	8 . Rol	timo	M M	021101
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		1	-			2 1 200	10	1	ングイン
	Registr	ar	NOV 0 8 2004 Seem 19	J.	pour	211						

DHMH 17 Rev 1/2001

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			For State Registrar		State of	Marylan		artment <i>rtificate</i>			and M	lental Hy	giene Reg. No. 0 () 4	3526	6
	Physici /Medic		1. Decedent's Nam	e (First, Middle ROBER		ΣR						2. Date of De Month NOVEM	Day	004	3. Time of Death	h M
	Examir		1208 FAL	CONETT		nber)		LARGO)	Location o			4c. County PRINC		ORGES	
	Funeral Director		5. Social Security N 247-74- Usual Residence of	1699	6. Sex X ☐ M 2☐ F	7. Age (In yrs. I	ast birthday) Yrs.	Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da 12-	31-44	Cour	place (State or Forentry) . C.	əign
	e Maryland Ba-f show Allied at	Director	10a. State MD.	10b. County Prince	e George		Larg							1	0d. Inside City Lin 1 X Yes 2 □	
	with th	Dire	10e. Street and Nu		ett Cou	ct		10f. Zip (Code 0774	ı			10g. Citizen of V		ntry?	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene item 27 is marked other than "natural", or itema 23s or 28s-1 show other traumatic event. The Medical Examinating the rediffied at	Completed by Funeral	11. Marital Status 1 □ Never Mari 3 □ Widowed	ried XXMarr 4 Divorced 15. Decedent city only highes	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da 's Education it grade completed)	dent Ever in U. rces? 2 No etes:	16a. Dece		ont of His fy Cubar No Occupa	spanic Origin, Mexican Specify: tion uring most	, Puerto I	11.2	14. Rac Blac	e - Americ ck, White,	ck	
212	d with giene.	mo	Elementary/Second 12th	ondary (0-12)	College (1	-4or 5+)	Off	ice E	res	smar	1		Fed.	Gov	't	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event. The Ma	To Be C	17. Father's Name Jam	(First, Middle, es Ter						18. Mothe	r's Name	(First, Middle	, Maiden Suman elder	7e)		
Man	2 should and Men is marke raumatic		19a. Informant's N										er, City or Town,		,	
Baltimore, A	Page nent o ant: if ury or		20a. Method of Dis	position Cremation	.der/Wife	20b. P	lace of Dispo emetery, crei rmony	nsition (Name matory or oth Mem.	e of her place Pa	rk 1	□ 1/0	6/04	rgo, Mo 20c. Location - Landov	City or To	md.	
Balt	permit. Page Department o Important: If any injury or ance.		21. Signature of Fi	uneral Service	Licensee	loni	2	2. Name and The F 814 –	Address Ious Ups	s of Facility e of hur	Wi Str	lliam:	s Funer	cal :	Svc	
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Ф	w requires that been signed b should be deta		Part II. Other signi	ficant condition	ens contributing to de	ath but not resu	ulting in the u	nderlying ca	use give	n in Part I.			obacco use conti Yes 2 □ No	ribute to th 3 ☐ Prob	e cause of death?	wn
Il Records,		Completed by									_	24a. Was autor perfo	osy primed?	rior to cor leath?	osy findings availa inpletion of cause of	ble of
on of Vital	Attanding Physician: The streath. sr death. srctor: After this certificate by the funeral director, pag	To Be	25. Was case referenced a reference of Dea 1 Natural 2 Accident] No	Hospital: 1 ☐ Ir	npatient 2 🗍 I of Injury h, Day Year)	ER/Outpatier 28b. Time of Injury		Othe Ic. Injury Work	r: 4□ Nur at	rsing Hon		dence 6 Other	1 7)	
Division	al or Attandi s after death. il Diractor: A id in by the fu	Certification	3 Suicide 4 Homicide	6 Could determ	ined 28e. Place	of Injury - At ho ng, etc. (Specify	nme, farm, str	eet, factory,	office		2	28f. Location (City or Tox	Street and Numb vn, State)	er or Rura	Route Number,	
	To the Hospital or Attanowithin 24 hours after death To tha Funarei Diractor:	Medical C	29a. Certifier (Check only one)	1 Certifyin	g Physicien: To the Exeminer: On the ba and mann	isis of examinat	wledge, death tion and/or in	n occurred a vestigation, i	t the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)	
)	Tot Tot com	Σ	29b. Signature and	title of certifie	2 Rol	lu	MO	29c.	License				29d. Date signed			
	7		PATRI	CIA -	who completed cause	-131A	<u> </u>		Stre	et, E	Balti	imore,	Maryland	1 212	01	
	Sta Registi		31. Date filed (Mor	nth, Day, Year)		egistrar's Signat	ture	-		4						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Oecedent's Name (First, Middle, Last) 2, 2004 **Physician** Mary Rita Gillespie 3:00 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath **Examiner** Silver Spring Montgomery 15310 Pine Orchard Drive, Apt 3-J If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 1)
Dec. 28, Birthplace (State or Foreign Country)
 Ohio 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖸 F Ĩ913 285-38-7802 90 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County it of Health and Mental Hygiene.
If item 27 Ia marked other than "natural; or Items 23s or 28s-f show or other traumatic event, Ite Madical Examine I: wat be notified at 1 ☐ Yes 2 No Silver Spring Directo Maryland Montgomery 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number death with 15310 Pine Orchard Drive #3-J 20906 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Zeno Fransesca Fiorella ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria J. Ward/Daughter 4609 Jasmine Drive, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages November 13, 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or Holy Cross Cemetery Akron, Ohio 2004 ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 0 23a. Part1. Error the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Immediate Physician Acute Myocardial Infarction /Medical resulting in death) Due to (or as a consequence of) Examiner 8 Years Coronary Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ner sician and burial-transit the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) signed by the a d be detached f ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Aortic Stenosis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 Yes 2 🗌 No 2 🔯 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 3 DOA 2 No 2 ER/Outpatient 2 1 X Yes this 28a. Oate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? 27. Manner of Death After Certification: Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 Homicide ō filled i Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D24543 November 3, 2004

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760,

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Records,

Division of Vital

3305 North Leisure World Blvd., Silver Spring, Maryland 20906

u a m mo

8 2004

James A. Rossi, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar		State of	f Marylar		artmen rtificat			and M	ental Hy	giene		05060
	Dhysici		1. Decedent's Name (First, M									2. Date of De		2004	வான் கூடும்
	Physicia /Medic	al	GEORGE GREGORY			- (4. 02.	T	1		Vaenbe			
	Examin	e.	4a. Facility Name (If not instit				land high day	BALT:	IMORE	Location of		2. Data of Bir		. County of Deat	'A
	Funeral Director		5. Social Security Number 223 36 4134		M 2□F	7. Age (In yrs.	77 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da EB. 27	Year)	926 VIRG	holace (State or Foreign unity) INIA
	fand ow		Usual Residence of Deceden 10a. State 10b. Co			10c. Ci	ity, Town or Lo	cation							10d. Inside City Limits
	a-f sh	ctor	MD	N/A	A	BAL	TIMORE								1 ☐¥es 2 ☐ No
	172 hours after death with the Maryland *natural*, or Itams 23e or 28e-f show rdical Ezata wit must be molified at	al Director	10e. Street and Number 5221 HARFORD I	ROAD				10f. Zip 212]					10g. Cit U.S.	tizen of What Co , ${\sf A}$.	untry?
	r deat	Funeral	11. Marital Status		Armed Fo		J.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)) -	14. Race - Ame Black, White	
336	urs afte	by F	1 ☐ Never Married 2 X 3 ☐ Widowed 4 ☐ Divo		1 ☐ Yes If Yes, Giv Year or Da	Θ		1 □ Yes	2 X No	Specify:				Specify: BL	ACK
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21215-0036	- 3	Completed	7th (0-	2)	College (1	-4or 5+)	LABORI	DO NOT us	se retired,)		•	CONS	STRUCTIO	N
d 2	be filed within 72 ho ital Hygiene, id other than *natur evant, tra Medical	a	17. Father's Name (First, Mid								er's Name	(First, Middle			
Maryland	should be filed within and Mental Hygiene. I marked other than umatic event, I to M	ToB	UNKNOWN		D		105 14-11			MILY					
	2 6 6 5	1	19a. Informant's Name/Rela GEORGE A. GREC											or Town, State, Z IARYLAND	
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 □ Creman	ion 3□F	lemoval from		Place of Dispo cemetery, crea	sition (Nar	ne of		D	ate 1,2004	20c. Lo	ocation - City or	
Itim	t. Pa rtmen rtant: njury	1	4 ☐ Snation 5 ☐ Other	r (Specify)			tersvi]	le Ba	ptis	st. Chi	irch	Cem. H	ucki	inghari C	o, Va.
Ba	Departing Department of the policy of the po		Munal	all	THA	rug	14	12 E.	PRE	STON	STRE	VIN B. ET BAL	SCR TIMO	RUGGS FU RE, MAR	NERAL HOME YLAND 21213
П			23a. Part1. Enter the diseas shock, or heart failure.	e, or compl List only or	ications that c ne cause on e	aused the da ach line.	1		1		cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
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8760,	icate by physic s the bu	dical			d										
9 xo	eath certific attending pl	ın/Me	IF FEMALE: 23b. Was decedent pregnan	. 2		come of pregn		Ectopic pr	20002004					23d. Date of deli	very
.O. B	The law requires that the death certificate be executed tens been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			ant at time of		Other (sp						Month	Day Year
<u>α</u>	es that the digned by the be detached	by Ph	Part II. Other significant cor	ditions co	ntributing to de	eath but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did 1	tobacco i	use contribute to	the cause of death?
ords	v require been sig should b											10	Yes 2	□No 3□Pro	obably 4 Unknown
Vital Records,	has be	Completed										24a. Was auto perfo		24b. Were au prior to death?	topsy findings available completion of cause of
tall	10	e Co	25. Was case referred to me	dicat						26 Place	of Death	1 ☐ Yes (Check only		1 □ Yes	2 □ No
f∨ï	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 □ I	npatient 2	ER/Outpatie	nt 3 DC	Othe					6 Other (Spec	city) hospice
on of			27. Manner of Death 1.☑Natural 5 □ Pe		28a. Date (Moni	of Injury th, Day Year)	28b. Time o Injury	f 2	8c. Injury Work	at ? /es 2 □ i		8d. Describe	how inju	ry occurred	
Division	tent leatl tor: the	Certification:	3 ☐ Suicide 6 ☐ C	restigation ould not be termined	28e. Place	of Injury - At h	nome, farm, st			193 2	-	8f. Location (City or To			ral Route Number,
٥		Cer		ifuina Dh				h occurred	at the turn	n date as	d place) and manner as	stated
	To the Hospite within 24 hours To the Funeral completely filled	ledicai			ner: On the ba									d place, and due	
	To t To tl	Ž	29b. Signature and title of ce	rtifies	∧ -			290	. License	number 854			29d. Da	te sighed (Month	Day, Year)
7	L		30. Name and address of pe	rson who co	ompled caus	e of death (Ite	m 23a) (Type,	Print)	2410	009					
_	V-1		Dav.D.	10.00	berg	301 5	T Par	ol Pi	Bo	Him	050	md.	15	202	
*	Sta Registi		31. Date filed (Month, Day, 1)			egistrar's Sign	ature 4	do	reli	,					
	ricgisti	CII	NOVU	ס בטטי	7	-	1	Jugar.	15031						

Gresonz, George

State of Maryland / Department of Health and Mental Hygiene 35269 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Yee **Physician** HARRISON HILDA November 2004 5:35 AM 05 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Baltimore Catonsville St. Joseph Nursing Home 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Jan 5, 1913 Birthplece (State or Foreign Country)
 Maryland 5. Social Security Number **Funeral** Days 1 □ M 2 🔀 F Yrs. 215-10-0308 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural; or items 23s or 25s-f show other traumetic event, the Modical Examinal must be notified at 1 ☐ Yes 2 ☑ No Baltimore Director Baltimore Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 4319 Spring Avenue Funeral permit. Peges 1 end 2 should be filed within 72 hours efter deeth Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White é 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Accounting Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Agatha Miller Louis Flaig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Rita Rattell / Niece 125 Hillside Road, Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/10/04 Baltimore, Maryland New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licens 4107 Wilkens Avenue, Baltimore, Maryland 21229 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only the gluse on each line. 23a. Part1. Enter the diseese, or shock, or heart failure. List Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) · Acure Myocardia 15 MINUTES Examiner es e consequence of): Physician/Medical Examiner ORONAR ettending physicien end for use es the bunel-trensit The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? as been signed by the 2 should be deteched 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 2 24b. Were autopsy findings Completed 24a. Was an autopsy performed? LEFT VENTRICULAR available prior to completion of cause of deeth? this certificate has page FUNCTION 1 ☐ Yes 25 No 1 Tes 2 4140 or Attanding Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Naturel To the Hospital or Attanding within 24 hours effer death.

To the Funeral Director: Aft completely filled in by the fun 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 6200 TTENDING feted cause of deeth (Item 23e) (Type, Print) M. MACHIRAN 720-CHAIDEN C ICELANE (31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture State

Registrar

NOV 0 8 2004

State of Maryland / Department of Health and Mental Hygiens 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Cotober 2004 0339 AM <u>Shirley Kaye</u> Hall/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Arundel Hospital Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 3€XF 214-48-1583 58 Yrs. Director 8, Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death win and Mental Hygiene.
Is marked othar than "natural", or Items 23a. 21060 United States 7885 Gordon Ct. Apt. 549 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 A Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Hannah Edward Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar trac Brooklyn Park, MD Linda Truelove - Sister 408 Old Riverside Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. Date 1 Burial 2 □ Cremation 3 □ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Glen HAven Mem. Pk. 2004 Glen Burnie, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cads: on each line. HROMBUTIC Immediate Cause (Final TIMOMBULY 12 PUNC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed ANEMIR that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by NEMIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 25 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 🗌 Yəs 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Peath 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation hours after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To tha I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060824 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITAL DRIVE GLEN BURNIE NNENNA OKIGBO MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 35271 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 4, HART 2004 8:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PASADENA HOME CARE PASADENA ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month Day, Year) 4/20/1920 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2000 230-30-2043 84 Yrs KENTUCKY Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event. It would be continued at MD ANNE ARUNDEL PASADENA 1 Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 KENTUCKY AVENUE 21122 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filad within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXVo Specify WHITE Specify 3 XXidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filad within 7 h and Menta! Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ENOCH CAUDILL MELVINA HOLCOMB 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD H. HART item 27 I 7507 OLD TELEGRAPH ROAD, APT F, SEVERN, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite ury or ot 1 Burial 2 Cremation A Removal from State permit. Page Depintment of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) MCNTEL FUNERAL HOME 11/05/2004 SNEEDVILLE. TN 21. Signature of Funda Store Liouse 22. Name and Address of Facility MARYLAND MORTUARY SUPPORT 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 KELLY GREGORY FINE #M01148 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician) orms /Medical Examiner Carre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed ensi Cal burial-tran (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2XXNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? (es XXNo certificate is after deau...
ral Diractor: After this ce..... 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Haspice Home Hospital: 10 Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes XX No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Certification: 28d. Describe how injury occurred XXNatural 5 Pending investigation 1 Tes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier icai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year)

Oi

State Registrar

31. Date filed (Month)

01

ME 32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of	of Maryland / Dep Ce	artment of ertificate o		and Me		ene 0	04	35272
	Physici /Medic		Decedent's Name (First, Midd BETTY	J.	HUDSON				2. Date of Death Month	Day 2	Yeer 🗘	3. Time of Death
}	Examin		4a. Facility Name (If not institution UNION MEMOR	. 3	,		, or Location o	of Death		4c. Count	y of Death	
	Funeral Director		5. Social Security Number 250-36-6237	6. Sex 1 □ M XX F	7. Age (In yrs. last birthday 76 Yrs.	Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day, 11/28/19	Year) 927	Cour	plece (State or Foreign ntry) ENVILLE, SC
	Maryland f show led al	tor	Usual Residence of Decedent 10a. State 10b. County MI WAY		10c. City, Town or L	ocation					1	10d. Inside City Limits 1 ☐ Yes XX No
	h the l	irect	10e. Street and Number			10f. Zip Code	•		10	g. Citizen of	What Cour	ntry?
	ath wit	raiD	12058 STRINGE	IAM COURT		4:	8213			U.	S.A.	
9000	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show he Mcdicel Examinat must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3XXVidowed 4 Divorced	ried 1 Yes If Yes, G Year or I	orces? 2XXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Was Decedent of If Yes, specify C	uban, Mexican lo <i>Specify:</i>	gin? (Spec , Puerto R	lican, etc.)	Speci		etc. LACK
21215-0036	l within 72 iene. r than "nat	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed, College ((Giv	edent's Usual Occ e kind of work dor DO NOT use reti	ne durina most	t of working	g	6b. Kind of E	estau:	
	uld be filed fental Hyg rked other tic svant,	To Be C	17. Father's Name (First, Middle, JOHNNY FOST						(First, Middle, M	aiden Suma		WINT
Maryland	nd 2 shouath and N 27 is mai		19a. Informant's Name/Relations ALLEN HUDSON	ship (Type, Print)		ing Address (Stre						Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be putified at once.			Specify)	State UNITED ME	osition (Name of ematory or other p M. GARDI 2. Name and Ado	Ins 1	1/06/ FIN	/2004 P NK FUNER	LYMOU! AL HO	- City or To TH, M ME, PA	I A
	Physician		RELLY GRE 23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause Ninal disease or condition	_	#11011-10		ying, such as o				E, MD	Approximate Interval Between Onset and Death
	/Medical Examiner	iner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Elian unue lying	Due to	(or as a consequence of): OTHER BOWS (or as a consequence of):	2	110				1	clay
,820,	icate be executed physicien and sthe burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequence of):							
P.O. Box 6	death certifi e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ Nb 9 □ Unknown	1 Live	nant at time of death 5	□Ectopic pregnar □ Other <i>(specify)</i>	ncy				ate of delive	ery Day Year
Ś	law requires that the death as been signed by the atte 2 should be detached for	by	Part II. Other significant conditi	ons contributing to c	death but not resulting in the	underlying cause	given in Part I.			cco use con	tribute to th	ne cause of death? ably 4 Munknown
Record	The la ate has page 2	Completed							24a. Was an autopsy performs		prior to cor death?	psy findings available mpletion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	11 25-1				of Death ((Check only one)			
of	Physic this stal direction	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 ER/Outpatie	nt 3L DOA			e 5 Residen			′)
Division	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director,	Certification:	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide deter	not be	e of Injury - At home, farm, sl ling, etc. (Specify)	M 1	□Yes 2□N	No.	Bf. Location (Stre City or Town,	et and Numi		l Route Number,
	To the Hospital or A within 24 hours efter To the Funeral Direction completely filled in b.	edical Ce	29a. Certifier 1 Certifyi (Check only one)	Exeminer: On the b	e best of my knowledge, dea pasis of examination and/or in their stated.	th occurred at the	time, date and opinion, deatl	d place, an	nd due to the cau d at the time, dat	se(s) and m e and place,	anner as st and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certific	2			nse number 43894 (-E18	$\beta = \mu$	Date signe	a	
_	Q		30. Name and address of person Union Memorial Ho 2018. University Pa		se of death (Item 23a) (Type	Print) Ana	e/a	Mor				
	Sta Registr	_	31. Date filed (Month, Day, Year NOV 0 8 200		Registrar's Signature	Ang Sparks				•		

Amend item#4b c, perfit, C837, 1178/04 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician IRWIN Month Day 2:07 PM NOVEMBER - 04 - 2004 ANE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. HARBOR CENTER HOSPITAL BALTIMORE BALTIMORO City 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign nth, Day, 160 Days Hours 1 □ M 2 🌣 F 83 217-24-5063 Director 1921 Maryland Usual Residence of Decedent the Maryland 10h County 10a State 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at Director Maryland Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Vernon Ave. 21061 United States itams 23a Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 Nidowed 4 Divorced White "natural" ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Complet (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Itam 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager Board of Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Kelly Mangum Mattie Pawn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Kornmann / Nephew 8057 Long Hill Rd., Pasadena, Maryland 21122 20a. Method of Disposition
1 ☑ Sprial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages i Department of t-Important: if ita any injury or oti once. cemetery, crematory or other place) November 8 2004 ' 4 □ D nation S □ Other (Specify) Glen Haven Mem. Park. Glen Burnie, Maryland 21. Signati of Fur Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 0 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPERTENSION 10 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 DAYS MYO CARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of) Examine physician and as the burial-transit VII. B 1 DAY INTRA CRANIAL The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 Ø No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate Division of Vital 2 1 No 2 No 1 Yes the Hospital or Attanding Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manher of Death 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after to the Funaral Dirac 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 000 RBS MI NOVEMBER-OH-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARKANDAYA, SHANONER STREET, BALTIMORE, MD, 21225 MANJUNATH 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

2004

State of Maryland / Department of Health and Mental Hygien 2004 35274 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2004 **Physician** Alverta Johnson 2:50P Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Millenium Nursing Home, N.W. Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Jan. 21 Birthplace (State or Foreign Country) **Funeral** 1945 Maryland 1 □ M 2√2 F 216-42-4309 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location Baltimore 10a. State 10b. Count ir than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Maryland N/ADirector X□Yes 2□No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4633 Reisterstown Road 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: ģ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If itam 27 le marked other than "ne any injury or other traumatic event, The Madig. 900. Dept. of Social mentary/Secondary (0-12) College (1-4or 5+) 10th grade Clerk/Typist Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dorsey Davis Mary Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code21215 4633 Reisterstown Rd Baltimore, Maryland David Carroll/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other of 20a. Method of Disposition 20c. Location - City or Town, State 11/9704 cemetery, crematory or other place) 11/9 Lorraine Park Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 4 ee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) granoma months /Medical Due to (or as a consequence of): **Examiner** Atherosel HO Vesca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Was al. autopsy performed? Yes 2 7No certificate 1□ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔁 No After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funaral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HILLARM 1) matyn

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State

Registrar

MAEEM 501

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 0 8 2004

31. Date filed (Month, Day, Year)

		-	For State Registrar	State of Ma	-	partment of F ertificate of t			ne 2004	35275
	Physicia		Decedent's Name (First, Middle,					2. Date of Death Month	Day Year	3. Time of Death 2'.05 PM
	/Medic	al	011-17	Kurtz		4. 6: - 7	1 10 10 1	NOU. 4	1 2004	a.05 PM
	Examin Funeral	G!	4a. Facility Name (If not institution, some of the Hard of the Social Security Number 6	el Has	(In yrs. last birthda	Clen i	Location of Death Surrie If Under 24 Hrs.	8. Date of Birth	4c. County of Death Anne P 9. Birthp	place (State or Foreign
	Director		359-20-9760	1 X 1M 2□F	74 Yrs	Months Days	Hours Min.	Dec. 25,	1929 II	linois
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				0d. Inside City Limits
	Maryl	ρ	Md. Anne A	rundel		Glen Bur	nie			1 ☐ Yes 2 X No
	n the	Irec	10e. Street and Number	l		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	th wit	a D	209 Water Fount	ain Ct. Uni	t 103	2106	50		USA	
396	d within 72 hours after death with the Maryland jiene. Than "natural", or Itams 23a or 28a-f show the Mapical Examinat must be nutified at	by Fur	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Wes 2 N If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ Wo	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
2-0	72 ho	eted	15. Decedent's	Education	16a. De	cedent's Usual Occup	ation during most of worki	na 161	b. Kind of Business/In	dustry
21	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life	e. DO NOT use retired	d)	g		
2	77 75 5		12 17. Father's Name (First, Middle, La	est)		Sailor	18. Mother's Name	(First, Middle, Mai	US Navy den Sumame)	
Maryland 21215-0036	Q 22 D 6	To Be	John		urtz		Leot		McCoy	
ary	2 should be and Menta Is marked aumatic ev	-	19a. Informant's Name/Relationship	о (Туре, Print)		ailing Address (Street				Code)
	1 and 2 Health a em 27 ls		Julia R. Kurtz	(Spouse)		Water Fou	The second secon		•	
altimore,	Pages 1 a nent of Hez int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		cemetery, o	sposition (Name of crematory or other place	ce)		c. Location - City or To	
Ħ		-	' 4 □ Donation 5 □ Other (Spe 21. Signa up of Fun 1 S Vide U		Metro (CfeMatory I	nc. 11-6	1-04 Bá	altimore, I uneral Hom	Md.
Ba	permit. Departr Importu any Inje	Ш	1 Aug 2.52	T. A.		3111 Mount				e ra
	Pnysician	6 74	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition					<u>·</u> _		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		consequence of):	0				
	Lauminer	-	Sequentially list conditions,	V. The second se	nyocardia	Interction	١			5 hours
17	uted J ansit	mlne	il any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Coronar	04	disegue				Years
oʻ	be executed sician and burial-transit	Examln	resulting in death) Last	Due to (or as a	consequence of):					
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9	eath certific attending p I for use as	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date of delay	201
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P.0	that the de led by the a detached i	Phys	9 Unknown	9□ Unknown						
Records,	The law requires that the death certifi ite has been signed by the attending rage 2 should be detached for use as	by	Part II. Other significant condition Type T Diabet	_	it not resulting in th	e underlying cause giv	en in Part I.	1 Tyes	co use contribute to the	ably 4 □Unknown
al Rec		Completed						24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
Vital	5 8 9	o Be	25. Was case referred to medical examiner?	Hospital:	- A	tiont 3C DOA Oth	26. Place of Death		• 500	
o	Phys er this eral dir	H=	1 ☐ Yes 2 № No 27. Manner of Death	28a. Date of Injur	y 28b. Tim	e of 28c. Injur	y at	ne 5 ∐ Residenc 28d. Describe how	e 6 ⊡Other (Specif injury occurred	y)
ion	Attending in death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Year) Injui		K? Yes 2□No			
Division	after death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin		iry - At home, farm, :. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura Itate)	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical Ce	29a. Certifier (Check only one) Certifying 2 Medical Expenses	Physician: To the best of teminer: On the basis of and manner sta	examination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, a pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier			29c. Licens	e number		Date signed (Month,	* * * * * * * * * * * * * * * * * * * *
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			suren s	farra mp		D 00	22483	N	00.4,20	04
-	411		30. Name and address of perso w STURET JACCE 31. Date filed (Month Pay Year)	c mn 304	eath (Item 23a) (Ty	pe, Print)	n Burnie,			04

			For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artment of F <i>tificate of l</i>	lealth and N <i>Death</i>	Mental Hy	giene () Reg. No.	04	3527	6
	Dhymini		Decedent's Name (First, Middle, I	_ast)					2. Date of De	aath Day	Year	3. Time of Dea	
	Physicia /Medic		Ronald Joseph K						Nov.	5, 20	004	11.70	Y M
	Examin	er	4a. Fecility Name (If not institution, g					r Location of Death		4c. Cou	nty of Death		
			Gilchrist Hospid		a /In ure	last birthday)	Baltimor If Under 1 Year		8 Date of Bi	th	Q Righ	place (State or Ec	veian
	Funeral Director		202-32-4388	357	63	Yrs.	Months Days	Hours Min.	8. Date of Bi	аў, _{Уваг)} 8 , 194]		place <i>(State or Fo</i> intry) INSVIVANI	
			Usual Residence of Decedent						JOONE I	0, 1941	- ren	IISĂTAGIIT	.a
	yland		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Li	
	a-fsl	Director	MD		Ba.	ltimor	е					1 Yes 2]No
	or 28	lre	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?	
	238 ust b	ral	135 W. Hill St				21230			USA			
	tema term	nue	11. Marital Status	12. Was Decedent Amed Forces?		S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.))- 14. F	łace - Ameri Black, White,		
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Ş	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or terme 23a or 28a-f show that the Mudical Eracultar must be notified at	Completed by Funeral	15. Decedent's	Education			dent's Usual Occup	pation		16b. Kind of	Business/In	ndustry	
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212	d with	ĕ	12	4		Eng	ineer			Luce	ent Te	chnologi	.es_
b	al Hy other	Bec	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	ne (First, Middle	, Maiden Sum	ame)		
<u>/a</u>	Ment Ment arked	2	Joseph Kodlick					Margaret					
4 ، Maryland 21215-0036	nd 2 should be filled with and Mental Hygie 27 is marked other traumatic event, In		19a. Informant's Name/Relationship					and Number or Ru				p Code)	
4.00	s 1 and 3 f Health item 27 other tr		Gladys Wheeler	- wife	20h B	_		reet, Ba	Itimore Date		21230 on - City or To	own State	
:	Se to		20a. Method of Disposition 1 Durial 2 Cremation 3	☐Removal from State			sition (Name of natory or other place					own, State	
40 mil	t. Partmen tant:		`4 □Donation 5 □Other (Spe		ват		Wash. Cr		7/04	Laure			_
l', l Bal	permit. Page Department Important: If any injury or		21. Signature of Funeral Service Lie			72	50 Washir	ss of Facility ufman Fun ngton Blv	d Elk	ridae,	adowri	idge MP, I 21075	inc.
6			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the deat	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	ın
	Pnysician		Immediate Cause (Final disease or condition	00	1.1	LAST	Joma 1	multi	form	e		Onset and Deat	th
	/Medical		resulting in death)	Due to or as	a conseq			71-				0	
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- 700	S 0	ompleted							24a. Was		b. Were auto	opsy findings avai	lable
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0 0	ng Pt fter tt ineral		27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	Wor	rk?	28d. Describe	how injury occ	urred		
Sol	Attending r death. ector: After by the fune	catl	2 Accident investiga 3 Suicide 6 Could no	t be				Yes 2 □ No	201 11	(0)		-10	
۵:∑	or Atl fter d irect n by	Certification:	4 Homicide determin	ed 28e. Place of Inj building, et	ury - At he c. <i>(Specil</i>	ome, farm, sti y)	eet, factory, office			wn, State)	mber or Hun	al Route Number,	
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1	o the o the omple	Med	29b. Signature and title of certifier	1-1			29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)	
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(4)	4		1) 1 1	my Ril	ey			Charles	Street	T'ov	vson,	ബ. 212	204
		ate	31. Date filed (Month, Day, Year)	2. Registr	ar's Signa	ature	M .						
	Regist	rar	NOV 0 8 20	104 Modern	, 10	April	42)						

DHMH 17 Rev 1/2001

Registrar

		-	_ FOI	epartment of Health and Me Sertificate of Death	ental Hygiene Reg. No	11114 35278
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
	Physicia /Medic		HELEN E.		DETOBER	29 2004 3:46 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
			Bon Secours Hospital	Baltimore [ay] If Under 1 Year If Under 24 Hrs. 8		N/A 9. Birthplace (State or Foreign
	Funeral		5. Social Security Number 2.1.7 - 2.0 - 1.369	Months Days Hours Min. 1	(Month, Day, Year)	1924 Maryland
	Director	1	Usual Residence of Decedent			
	yland		10a. State 10b. County 10c. City, Town of Maryland N/A Balti			10d. Inside City Limits
	a-fal	cto	Maryland N/A Balti			1X Yes 2 □ No
	h with the	ai Dire	10e. Street and Number 246 N. Mount Street	10f. Zip Code 21223	10g. Ci	itizen of What Country? USA
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depriment of Health and Mental Hygiene. Depriment of Health and Mental Hygiene. In principal is a marked other then "natural", or itema 23e or 28e-f ahow my injury or other traumatic event, it a Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes ※ No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Speci起lack
21215-0036	hour fural		15 Decedent's Education 16a D	ecedent's Usual Occupation	16b. F	Kind of Business/Industry
7	in 72 n "na	Completed	(Specify only highest grade completed)	give kind of work done during most of working fe. DO NOT use retired)	⁹ Bon	Secours Hospital
2	y with	шо	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade C]	.erk/ Cashier		
and ;	ould be filed Mental Hyg arked othe atic event,	a l	17. Father's Name (First, Middle, Last) Basil Mercer	18. Mother's Name Emma Mu	(First, Middle, Maider rray	n Sumame)
Mary	and 2 should ealth and Men n 27 is marke ier traumatic	-	19a. Informant's Name/Relationship (Type, Print) Elaine Judkins-Branch/Niece 70	Mailing Address (Street and Number or Rural 19 N. Calhoun Stre	Route Number, City eet Balt	or Town, State, Zip Code) imore, Md 21223
Baltimore, Maryland	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other ance.		20a. Method of Disposition 1 Donation 5 Other (Specify) 20b. Place of D comptony Arbutus Arbutus	isposition (Name of crematory or other place) Memorial Park 1 1		
Baltin	permit. F Deportm Importer any injur		21. Signature of Funeral Service Wansee	22. Name and Address of Facilic hat 1 5240 Reisterstown	man-Harr n Rd Bal	is Funeral Home timore,Md 21215
	_		23a. Part. Enter the disease, or complications that caused the death. Do no spock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician	1 115		YOCARDIAL IT	NFARCT	Onset and Death
	/Medical		Due to (or as a consequence of)	1		
	Examiner		ACUTE CE	REBRO-VASENZ	AR ACC	IDENT 8 LAS
	p =	iner				
	cate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of)	ILLEROTIC NE	BET DI	SEASE NAKNOWA
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8760,	physic the b	edicai	d			
9 x	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
P.0	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds,	uires sign ld be	d by	HYPERTENTIOD		1 ☐ Yes 2	2 No 3 Probably 4 DUnknown
Vital Records,	e law req has beer je 2 shou	Completed	CARCINOMIA OF 57	OMACH.	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ᆵ					performed? 1 ☐ Yes 2 🗖 N	o 1 Tyes 2 No
Vit.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp	26. Place of Death		C [[Other (Core/h)]
ō	Phys r this ral dii	-: To	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outp 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 1/27 Natural 5 Pending	ne of 28c, Injury at 2	ne 5 🗌 Residence 8d. Describe how inju	
	Attending or death. ector: After by the funer	tion	1/2√Natural 5 ☐ Pending (Month, Day Year) Inj 2 ☐ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No		
Division	f or Attendil after death. Director: A	fica	3 Suicide 6 Could not be 28e. Place of Injury · At home, farm	n, street, factory, office		and Number or Rural Route Number,
D	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Star	10)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occurre	d at the time, date ar	nd place, and due to the cause(s)
	vithin To the compl	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
) .			I sold mo.	A 23300	0	CTOBER 29 2009
1	ω		30. Name and address of person who completed cause of death (Item 23a) (T SUDHIR, DAPATEL, 210	ype, Print) 130N BECUL	125 HUS	6F3 ALTY MD 21223
	Sta Regist	ate rar	31. Date filed (Manifold), 10-8 2004 32. Publistrar's Signature	29c. License number D 23300 ype, Print) 13eN BELUZ M 13ALTI MORE G Aparla		
	3.0			- 4		

		-	1- For State of Maryland / Departr Registrar Certific	ment of Health and Me icate of Death	ental Hygie Reg		35279
	Physicia		1. Decedent's Name (First, Middle, Last) Lorraine Margaret Medley		2. Date of Death Month November	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b	City, Town, or Location of Death		4c. County of Death	10000
	Funeral Director			Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Y April 2	9. Birthpl 9, 1929 Ma	ace (State or Foreign ry) ryland
	aryland show	2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimo	on			od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	Directo		01. Zip Code 21 21 6		. Citizen of What Count	
	be filed within 72 hours after death with the Marylan Hygiene. de thygiene. activities or 28a-f show avant, the Medical Examination at avant, the Medical Examination at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married	Decedent of Hispanic Origin? (Spec s, specify Cuban, Mexican, Puerto F Yes X No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Bla	tc.
1215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	s Usual Occupation of of work done during most of workin NOT use retired) memaker	g	sb. Kind of Business/Ind	ustry
and z		To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name Mabel			
Mary	l and 2 should tealth and Men im 27 is marke her traumatic	ř	19a. Informant's Name/Relationship (Type, Print) Diane Fitzgerald/ Granddaughter 4	ddress (Street and Number or Rural 310 SpringWoo	Route Number, C d Avenu	City or Town, State, Zip e Baltimo	Code) 21 206 Dre, Md
altimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify), 20b. Place of Disposition cemetery, cremato Loudon Pa	n (Name of ny or other place) 11/5 ark Cemetery		c. Location - City or Tov ltimore, M	
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice is e 22. Na 5 24 0	ame and Address of Facility Cha Reisterstown	tman-Ha Rd Bal	rris Fune timore,Mo	eral Home 1 21215
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock of heart fature. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	e mode of dying, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death NEWE NOVE-S
	Examiner	iner	b. Due to (or as a cohsequence of): Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events	hy		f ₀	UR YEARS
8/60,	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of): d. ACUTE (0)	ARDIAL IN	PARCTI	ion th	irty-six hours
O. Box 6	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ect 4 □ Pregnant at time of death 5 □ Oth	opic pregnancy her (specify)		23d. Date of deliver Month	Y Day Year
ds, P	uires that signed b lld be deta	by	Capital Significant containing to death but not resulting in the thirds	lying cause given in Part I.	23e. Did tobad	cco use contribute to the	a cause of death?
Records,	: The law requires that the cate has been signed by the page 2 should be detache.	Completed	OBESITY DIABETES MELLITUS		24a. Was an autopsy performe	prior to com death?	sy findings available apletion of cause of
Vital	ystcian: Th is certificate director, pag	o Be		26. Place of Death Other: 4 Nursing Horr		ce 6 □Other (Specify)	1
on of	ding Phy h. After this funeral c	 			8d. Describe how		
Division	a Hospital or Attandi 24 hours after death. a Funaral Diractor: A etely filled in by the ft	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)		8f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C					
ļ	To tha l within 2 To tha complet	Me	29b. Signature and tiple of certifier Sale MD ATTENDING PHYSICIAN	29c. License number	290	Neverber	
	7	1	30. Name and address of person, who completed cause of death (Item 23a) Type, Prin			And the Art of Management	
\$ · · ·	Sta Registi		A Sate filed (Month Day Your) 20 Denistrada Simplera	Sparks			

Medley, Lorraine

		State of Maryland / Departmen State of Maryland / Departmen State of Maryland / Departmen			ental Hygie	/11114	35280
Physicia	ın	Decedent's Name (First, Middle, Last)		2		Day Year	3. Time of Death
/Medic Examine		Sue Anne McCulloh 4a. Facility Name (If not institution, give street and number) 4b. City,	, Town, or	Location of Death	CTOBER	4c. County of Dea	
Examin			Baltin			n/a	
Funeral Director		5. Social Security Number 6. Sex 1 M 2K F 7. Age (In yrs. last birthday) 1 Months 7. Age (In yrs. last birthday) 4 Months 1 Months 7. Age (In yrs. last birthday) 50 Yrs.	Days	Hours Min.	. Date of Birth (Month, Day, Ye		rthplace (State or Foreign ountry)
ъ		Usual Residence of Decedent		E	ug 15, 1	954 Ma	ryland
farylar show	ō	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Catonsville					10d. Inside City Limits 1 ☐ Yes 2√ No
the M	rect	10e. Street and Number 10f. Zip	p Code		10g.	Citizen of What C	
th with	ai Di	107 South Paradise Avenue 2	21228		U	Inited St	ates
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. Applications: If time 27 to marked other than "neturel; or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinar must be notified anone.	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Spe		spanic Origin? (Speci h, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Am Black, Whi Specify:	
5-00 72 hot neture	eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of wo	ial Occupations do	tion uring most of working	166	o. Kind of Business	s/Industry
within ane.	Completed	Elementary/Secondary (0-12) Gollege (1-4or 5+)		None			
d 2 filled 2 Hygie other ent, I	Be Co	17. Father's Name (First, Middle, Last)	one	18. Mother's Name (First, Middle, Mai		
Vian vuid be Menta srked	To B	Richard N. McCulloh	.ly				
Maryland 21215-0036 and 2 should be filed within 72 hours aft with and Mantal Hyginary 271e marked other than "neturel", or retreumatic event, the Marical Examination of the control of t				nd Number or Rural I adise Aven		•	Zip Code) 21228 Marvland
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Baltimore, permit. Pages 1 at Department of the Importent: If then any injury or other once.				^{s of Facility} Hubb ens Avenue			, Inc. yland 21229
- Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition and provided in the state of					Approximate Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of):					
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)					WEEKS
cuted	Examiner	that initiated events	100				WEEKS
8760, ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				SOYEARS	
687 tillicate t	edicai	O CEREARAL PAL	-2 Y				SUTEARS
PECONDS, P.O. Box 68 The law requires that the death certification has been signed by the attending phage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (sp. 9 ☐ Unknown)				23d. Date of de Month	olivery Day Year
ds, P. (ds, p. (ds) that the signed by id be detacted	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying of ACUTE PROCTOCULITIS	23e. Did tobac	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown			
L OH, II Record The law requir, sate has been si page 2 should I	Completed			24b. Were autopsy findings available prior to completion of cause of death? 1. **D**+** as 2 \sum No			
of Vital F Physicien: Th this certificate	Bec	25. Was case referred to medical examiner?		26. Place of Death (1	
Phys ral dil	. To	1 Yes 2 No Hospital: 1 Tatient 2 ER/Outpatient 3 DC 27. Manner of Deal 28a. Date of Injury 28b. Time of 2		4 Nursing Home	5 Residence	e 6 Other (Spe	acify)
. E . # 5	ation	1 St Natural 5 ☐ Pending (Month Day Year) Injury 2 ☐ accident investigation M	28c. Injury Work' 1 □ Y	? 'es 2□No		,,	
Division Division Division 12 A hours after death. Per June of Jun	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office	28	f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
Divi	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred 2 Medicel Exeminer: On the basis of examination and/or investigation and manner stated.	n, in my opi	inion, death occurred	at the time, date	and place, and du	e to the cause(s)
To the within 2 To the complete	Ž		c. License			Date signed (Mon	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00	03735	19 NO	VEMBE	A 1,2004
× ×		KRIS M. SHEKITKA, MD 900 CATON AU	E !	BALTIMO.	es mo	21334	,
Sta Registr		31. Date filod (Month, Day, Year) 32. Registrar's Signature	box				

		1	For State Registrar	State of M	laryland	/ Depa	artment o	of Health of Deat	n and Me		giene Reg. No.	004	35281	
	Physicia /Medic	an	. Decedent's Name (First, Midd Marjorie Melvin	e, Last)						2. Date of Dea Month	ath Day	Year 4, 270	3. Time of Death	
	Examin	er 4	a. Facility Name (If not institution Saint Jose	oh Medical	Cent				Towso				timore	
	Funeral Director	2	i. Social Security Number 220-16-9767 Jsual Residence of Decedent	6. Sex 7. A 1 □ M 2 🕱 F	ige (In yrs. las	Yrs.	If Under 1 Y	ays Hours	s Min.	8. Date of Birt (Month, Da 10-08-19	n y, Year) 913	Co	hplace (State or Foreign untry) uryland	
	Maryland		MD 10a. State 10b. County	NA	10c. City,	Town or Lo	cation Balti	more					10d. Inside City Limits 1 X Yes 2 □ No	
	th with the 23e or 28e 1st be nut	줍	10e. Street and Number 5600 Bellona Avenue				10f. Zip Co	ode 21212				0g. Citizen of What Country? USA		
36	rs after deat		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:				Was Deceden f Yes, specify 1 ☐ Yes 2 ☐			cify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify:		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show entry injury or other treumetic event, the Madical Examinating the natified at angle.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk						nost of workin	16b. Kind of Business/Industry			Industry	
and 21	id be filed w ental Hygiei ked other ti ic event, th	To Be Co	17. Father's Name (First, Middle	Last) unknown				18. Mc	other's Name	(First, Middle,		eparunent Sumame) ur		
Maryland	nd 2 shou lith and M 27 Is mar		19a. Informant's Name/Relation Artie Shaw/ Guard							re, MD 2		Town, State, 2	Zip Code)	
altimore,	Pages 1 ar		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (te cen	netery, crei	sition (Name matory or othe .1e Cemet	r place)	11-09-	o4		nsville,	Town, State , Maryland	
Balti	permit. Departn Importe eny inju		21. Signatur of Funeral Sovice	[[1][hyl-				Funeral	Home 63			treet Bal	lto, MD 21217	
	Pnysician		23a Aart1. Enter the disease, shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)	t only one cause on each	iline.		er the mode of	of dying, such	as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner	-E	Sequentially list conditions, if any, leading to immediate	b. DEHYL	Due to (or as a consequence of): b. De HYLKATON Due to (or as a consequence of):									
8760,	cate be executed by sician and the burial-transit	Ical Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. PENAL Due to (or	c. Due to (or as a consequence of):									
.O. Box 68	ath certific attending p for use as	Physician/Medi	Part II. Other significant conditions contributing to death but not resolving in the olidenying cause given in a with								2	3d. Date of de Month	Date of delivery Month Day Year	
Δ.	luires that the de n signed by the a lid be detached i	by											o the cause of death?	
Records,	The faw requir ate has been si page 2 should	Completed								24a. Was autoj perfo		24b. Were at prior to death?	utopsy findings available completion of cause of	
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medic examiner? 1 Tyes 2 X No	al Hospital: 1 X Inp.	atient 2□E	R/Outpatie	nt 3 DOA	Other		(Check only one 5 Resi		S □Other (Spe	icify)	
Division of	tending leath. tor: After the fune	Certification; T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Coul	tigation	njury Day Year) Injury - At hon	28b. Time of Injury	М	. Injury at Work? 1 □ Yes 2	2 □No	28d. Describe			ural Route Number,	
Divi	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director:		4 Homicide dete	ing Physician: To the be	etc. (Specify)					City or To	wn, State))		
	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in I	Medical	(Check only one) 2 Medical Me	el Examiner: On the basi and manner	s of examination stated.	on and/or in	nvestigation, ir	my opinion, icense numb	death occurr	ed at the time,	date and	place, and due	e to the cause(s)	
	+ 3 + ŏ		30. Name and address of person		of death (Item)	23a) (Type		41410	l _e	-	me	mula US	1h, 2004.	
		ate	31: Date file MOV. Dryg et	14 mm 1 1 2 mm 2 3 4 4 7 3 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1	īstrar's Sīgnan	(20)	ER DE		OWSCN	I, MARY	LANI		14	
	Regist	rar		1-1	/	-	Spork	2						

			1 - State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>	lealth and M Death	lental Hygi Re	ene 2004	35282
	Physici /Medic		1. Decedent's Name (First, Middle, La Charles Preston					2. Date of Death Month November	Day Year	3. Time of Death 2:00 P M
	Examin		4a. Facility Name (If not institution, given 10015 Sterling Te		r)	4b. City, Town, or Rockvill	Location of Death		4c. County of Dea Montgome	th
	Funeral Director		5. Social Security Number 6.		nge (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 8,	Year) 9. Bir	thplace (State or Foreign buntry) hington, DC
	ryland thow	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	th the Ma or 28a-f s	Director	Maryland Montgom		Rockville	10f. Zip Code		10	g. Citizen of What Co	
	eath wi	eral	10015 Sterling Te	rrace	t Ever in II C 12 1	20850	ispania Origina /Sp.	noity You or No	United St	
036 urs after de		by Funeral	1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces	No WWII	was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 【图 No	ispanic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	te, etc.
Maryland 21215-0036	s filed within 72 hours after death with the Maryland I Hygiene. other then "naturel", or Items 23e or 28e-f show ont. I're M. Ofcel Ex. citref rust be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation rade completed) College (1-40	(Give life. I		during most of worki)	na	6b. Kind of Business Iontgomery Governm	County
d 2	il Hygi other	Be Co	17. Father's Name (First, Middle, Las	<i>t</i>)	ASSIST	tant Mana	18. Mother's Name	e (First, Middle, M		enc
ylar		ToE	George Mehrling	T	Can as we		Eva Burr			
	nd 2 sulth ar	1 8	19a. Informant's Name/Relationship Charles Kenneth M						City or Town, State.	
Baltimore,	ott et		20a. Method of Disposition 1 Burial 2 Cremation 3 Other (Special Control C		20b. Place of Dispo	sition (Name of natory or other place 1017		Date 2 5,	ethesda, M	Town, State
Balt	permit. Page Department of Importent: If eny Injury or once.		21. Signature of Funeral Service Use	1 1/1/	22	2. Name and Addres	s of Facility Rob	ert A. F		uneral Home/
	Physician		23a. Fart1. Enter the disease, or conspock, or heart failure. List only immediate Cause (Final	nplications that cause one cause on each	ed the death. Do not ent line.	er the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. Due to (or a	s a consequence of):	Chev				
		ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or a	s a consequence of):					
68760,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
	rtificate ng phys as the	Medicai	IC CENAL C.	d						
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
<u>α</u>	w requires that i been signed by should be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	The law re cate has bee page 2 sho	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
Vital	sician: certific rector,	o Be (25. Was case referred to medical examiner?	Hospital:	-5	• actions Other	26. Place of Death		-	
of		\vdash	1 Yes 2 M6 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		28c. Injury Work	at Rursing Ho	me 5 Pesider 28d. Describe hov	nce 6 Other (Spe w injury occurred	cify)
Division	tel or Attendi s after death. el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of I	njury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical (29a. Certifying P (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the bes miner: On the basis and manner:	st of my knowledge, death of examination and/or in- stated.	n occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurr	and due to the called at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To t Withi	Σ	29b. Signature and title of certifier	101		29c. License		1	d. Date signed (Mont	
,	127)		30. Name and address of ten on who	completed cause of	death (Item 23a) (Type.	Print)	8757	I	twember:	3, 2004
	10		Gary B. Wil	Ks, MID.	6121 m	untrose 1	Road 1	Rockville	Maryla	2004
	Sta Registi		31. Date filed\(Month, Day, Year)		trar's Signature	4 Som	No.		1	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician A^{M} Jeremy Eldridge Mason November 4, 2004 6:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☑ M 2 🗆 F 77 045-26-1048 Yrs. Dec. 3, 1926 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5513 Brite Drive 20817-6304 United States or Items 23e Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 X Yes 2 No WWII
If Yes, Give
Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Owens Corning 12 should be filed within the and Mental Hygiene.
7 Is marked other then "I Elementary/Secondary (0-12) College (1-4or 5+) Fiber Glass Sales Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked teny injury or other treumatic events. Hildegarde Eldridge Donald Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5513 Brite Drive, Bethesda, Maryland 20817-6304 Margaret W. Mason/ Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Montgomery November 5. 1 ☐ Burial 2 Toremation 3 ☐ Removal from State 2004 Bethesda, Maryland ¹ 4 □ Donation 5 □ Other (Specify) Crematorium, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service MOQ689 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock or higher tailure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hernowhys Shock Approximate Interval Between Onset and Death Pnysician /Medical 12 hours Examiner Gastrointestinal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed Due to (or as consequence of) Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?
Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۴ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural Certification; Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) November 4, 2004 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (121 GHANSHYAM GUPTA 32. Registrar's Signature 31. Date filed (Month, Registrar

Nason, Jeremy 11-4-04

		1	State Registrar AMEND ITEM #8 P	e of Maryland /	Depai 1968	rtment iifiogate	of He Hpf D	alth a eath		Re	g. No.	104	35284	
	Physicia		Decedent's Name (First, Middle, Last) . TORTTA MCGILL							2. Date of Death Month	Bay	04 04	3. Time of Death 0940 A _M	
	/Medic Examin		a. Facility Name (If not institution, give street and JOHNS I HOPKINS BRYY)	number) ELU CARE	er.	4b. City, To BAL	own, or L	ocation of	e		4c. Cou	nty of Death		
	Funeral Director		S. Social Security Number 230560351 6. Sex 1□ M 2	7. Age (In yrs. last b	Yrs.	If Under 1 Months	Year Days	Hours 2	Min.	8. Date of Birth (Month, Day,	7-10-1 7997 772-6	920 Sirth	place (State or Foreign ntry) KY	
	nyland bhow dal	. [Jsual Residence of Decedent 10a. State 10b. County	10c. City, To									10d. Inside City Limits 1 X Yes 2 □ No	
	death with the Maryland me 23a or 28e-f ehow	Director	MD NA 10e. Street and Number	Balt	TIIIOI	10f. Zip C	Code			10	g. Citizen	of What Cou	intry?	
	th with	ai Di	701 Gun Road				212					S.A.	4.6.	
36	be filed within 72 hours after death with the Marylan Hygiene. de Hygiene. de other than 'netural', or lieme 23a or 28e-f show event, the Medical Examination and the notified at	by Funeral	130 Never Married 2 Married 1	Decedent Ever in U.S. ed Forces? Yes 2 No s, Give or Dates:	1	Vas Decede Yes, specif	-	panic Orig , Mexican Specify:	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	E	Race - Ameri Black, White Icify:		
21215-0036	tiled within 72 hours after Hygiene. Ither then "netural", or Ite inther the Medical Examins	Completed	15. Decedent's Education (Specify only highest grade completion Elementary/Secondary (0-12) Colle		(Give H	ent's Usual kind of work OO NOT use	done du retired)	ion iring most	t of workir	ng	Obla	Business/I	ster	
212	ed with ygiene ygiene t, the	Com	12th grade na		Trea	asure		18 Mothe	r's Name	(First, Middle, N		rovio	ience	
_	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	ae Be	17. Father's Name (First, Middle, Last) Joseph McGill				M	larga	aret	Bell	Pric	е		
Jan	2 sho and h		19a. Informant's Name/Relationship (Type, Prin Sister Ricardo Mad							l Route Number, .more ≠,		wn, State, Zi 21227		
nore, l	permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked eny injury or other traumatic en <u>once</u> .	Ī	20a. Method of Disposition 1\(\text{Descript}\) Burial 2 \(\text{Cremation} \) 3 \(\text{Removal} \) 1 \(\text{Donation} \) 5 \(\text{Other} \) (Specify)	20b. Place ceme	of Dispos tery, crem	sition (Name natory or oth Park)	D	ate		on - City or I		
Baltimore,	permit. Pi Departme Important eny injury		21. Signature of Funeral Service Licenses			21215								
40	Pnysician /Medical Examiner	resulting in death) Due to (or as a pinsequence of):											Approximate Interval Between Onset and Death	
8760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of): Due to (or as a consequence of): c. If yes, outcome of pregnancy 1										
P.O. Box 68	he death certifica r the attending ph ched for use as th	Physician/Med	in the past 12 months?								23d.	Date of deli Month	very Day Year	
	uires that t signed by Id be deta	þ	Part II. Other significant conditions contribution	g to death out not resultin	g in the u	nderlying ca	ause give	n in Part I	l.		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkno			
Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed	Heart for	lure						24a. Was a autops perform	sy prior to completion of cause of			
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			-0-0	Othe	10.00		Check onl on		Other (Con	n/4/1	
of	ing Phys	tion: To	27. Manner of Death 1 Natural 5 Pending	10 Spital: 1 Inpatient 2 ER/Outpatient 3 DOA Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how										
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	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Physicien: (Check only one) 2 Medicel Exeminer: O	To the best of my knowle the basis of examination d manner stated.	dge, deat and/or in	h occurred avestigation,	at the tim , in my of	ne, date ar pinion, dea	nd place, ath occur	and due to the c red at the time, d	ause(s) and late and pla	d manner as ice, and due	s stated. to the cause(s)	
	To the vithin To the comple	Me	29b. Signature and title of certifier 29d. Date signed (Mor										h, Day, Year)	
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_	\		30. Name and address of person who complete	CANE		Print)	H	BM	رح	,				
	S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature		Spork	En!							

State of Maryland / Department of Health and Mental Hygiens Officertificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** November 3, 2004 5:07 A M Jean Marie Nelson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilcrest Hospice Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🖾 F Director 48 2/10/1956 Maryland 215-68-3707 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Arbutus Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5510 Willys Ave 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Dates: Completed by White 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 is marked other than *r 4+ College (1-4or 5+) Elementary/Secondary (0-12) Horse Caretaker <u>Equestrian</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harding T. Keene Doris M. Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an ant: If item 27 is 5510 Willys Ave Arbutus, Maryland 21227 Timothy G. Nelson / husband other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. Bayview Crematory 11/3/2004 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility $Ambrose \;\; Funeral \;\; Home, \;\; Inc.$ 21. Signature of Funeral Savice Licenses Part1. Enter the Isease, or complication that it used the shock, or heart failure. List only one cause on each line. 1328 Sulphur Spring Rd. Baltimore, Maryland 21227 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** Ung CANCER sear /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsuguence of Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 □ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) _ o. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Vital director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No Certification: To o in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of De ath 28b. Time of 28c. Injury at Work? Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 within 24 hours a

To the Funeral E

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 025205 Vovember 3, 2004 , mo 30. Name and address of person who pleted cause de th (Item 23a) (Type, Print) 6601 N. Charles Street Towson, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Genera & Spark NOV 0 8 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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NOVEMB

NELSON

State of Maryland / Department of Health and Mental Hygiere 0 0 4 35286 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)) etcher /ear **Physician** pha 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctor's Community Hospital Lanham Hours Min. B. Date of Birth (Month, Day, Year) Pec. 17, 1923 Riceville, TN If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗓 F Yrs. 80 Director 408-34-6887 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner rust be nutflied at 1 Yes 2 No Virginia Prince William Director Woodbridge 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 U.S.A. 22191 15016 Blackburn Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 6 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: White 3 X Widowed 4 ☐ Divorced "naturai". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is markad other than "n Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maggie Simpson Frank Dodson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an Department of Health a Important: If itam 27 is any injury or other trangone. Doug Nash (Son) 623 4th St. S.W. Washington, DC 20024 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Cemetery 11/5/2004 Rockwood, TN 21. Signature of Funeral Service License 22. Name and Address of Facility
Evans Mortuary mein 805 N. Gateway Ave., Rockwood, TN 37854 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 120Spirator /Medical Due to (or as a consequence of) Examiner reumon. Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit tusta Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ρ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 12 NO 1 ☐ Yes 2 No 1 Tes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical within 2 To tha To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDDGGGH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUCK Road, Lanham, MD 8118 G-00D F. ASPSA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 8 2004

				partment of Health and Mental ertificate of Death	Hygiene 004	35287						
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date	of Death	3. Time of Death						
	/Medic	al	JOS1E	PATT EKSON NOV	67BBL 04, 2	004 06:33 M						
	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death	4c. County of De	ath						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		N/A of Birth 9. B	irthplace (State or Foreign						
	Director		216-20-2862 1 M 2 F 79 Yrs.	Months Days Hours Min. (Month June	e 8, 1925 N	N.Carolina						
	riand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location		10d. Inside City Limits						
	Many ma-f sh	tor	Maryland N/A Bal	timore		XXYes 2 □ No						
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?						
	a 23a	rai	2043 Cliftwood Avenue	21213	USA							
"	fter de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	or No- 14. Race - Arr C.) Black, Wh							
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ylar		ToE	Edward Thomas	Josie Camer								
Maryland 21215-0036	12 and 12		19a. Informant's Name/Relationship (Type, Print) 19b. Mai Elon Burley/ Daughter 2041	iling Address <i>(Street and Number or Rural Route N</i> 3 Cliftwood Avenue H	tumber, City or Town, State, Baltimore.	Zip Code) Md 21213						
ore,	ges 1 and t of Healt if Item 2 or other		20a. Method of Disposition 20b. Place of Disposition		20c Location - City o							
Baltimore,	Pages ment of I tant: if Its		·4 Donation 5 Other (Specify) Druid I	Ridge Cemetery	Pikesvill	e, Marylan						
Balt	permit. Page Department of Important: if any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Chatmar 5240 Reisterstown Ro	n-Harris Fu Baltimore	neral Home , Md 21215						
	*		23a. Part 1. Ther the disease, or complications that caused the death. Do not exchange from the property of th	nter the mode of dying, such as cardiac or respirate	ory arrest,	Approximate Interval Between						
	Physician / /Medical			HYMAL MEMORRNA	-GE	Onset and Death						
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Вох	eath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of de							
-	it the dea by the al tached fo		1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month	Day Year						
, P.O	The law requires that the death certif te has been signed by the attending page 2 should be detached for use a:	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. I	Did tobacco use contribute t	to the cause of death?						
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n 01	ding Ph h. After thi funeral	Ju: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Injury (Month, Day Ye	of 28c. Injury at 28d. Descr	ribe how injury occurred	эспу)						
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Division	l or At after d Direct I in by	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Locati City or	ion (Street and Number or R r Town, State)	(Street and Number or Rural Route Number, own, State)						
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only 2 Madical Examiner: On the basis of examination and/or i	ath occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the ti	the cause(s) and manner a	s stated.						
	othe	Med	one) and manner stated. 29b. Signature and title of certifies.	29c. License number	29d. Date signed (Mon							
	->-0		Maral M.D.	RES-000	NOVEMBER							
4			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)								
(000			NETRAT NAVAL 600 NORTH W 31. Date filed (Month, Dan Ph) 0 2 2003P. Registrar Signature	& Sparks	MORE MD-	21287						
2	Sta Registr	-	31. Date filed (Month, Dal 10 V) 0 8 20032. Registrate Signature	19 Sparks								

		Registrar 1. Decedent's Name						inouto or i	lealth and N Death	2. Date of De	aath		3. Time of Death	-
Physici /Medio		Barbara	A. Willis	s Paigo	Bart	oara A	nn Wi	llis		OCT.	31, 2	004	10:15 A ^M	_
Examir		4a. Facility Name (II 1116 A	f not institution, RGYLE A	-	number)				r Location of Death		4c. Cour	ty of Death		
Funeral Director		5. Social Security N 214-64-0124		6.Sex 1 □ M 2 🛣 F		e (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 06-24-1	rth ay, <i>Year)</i> 952	9. Birthe Cour Mary	lace (State or Foreigi try) land	7
ow ow		Usual Residence of 10a. State	10b. County			10c. City, 7	Town or Loc	ation				1	0d. Inside City Limits	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event. I've Modical Exam har must be notified at once.	ctor	MD	N	Ά 			Baltir	·					1X Yes 2 □ No	
Sa or 2	Funeral Director	10e. Street and Nur 1433 Argyle						10f. Zip Code 21217	7		10g. Citizen o	What Cour	ntry?	
rews	nera	11. Marital Status	Avenue	12. Was D	ecedent l Forces?	Ever in U.S.	13. V		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	o- 14. R	ce - Americ		_
r, or ite	by Fu	1 X Never Marri 3 □ Widowed		ld 1 ☐ Ye if Yes,	s 2 📉 N	No	1	☐ Yes 2 No	Specify:	7 Hours, 010.7		Black, White, etc. Specify:		
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tem 2		20a. Method of Disp		Daugneer		20b. Plac	e of Dispos	3 Ar ₃ v1e Av sition (Name of latory or other place	venue Balti	Date PID	20c. Location	· City or To	own, State	
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physician and sthe burial-transit	dical Examiner	Sequentially list co if any, basing to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	erlying injury s	b	to (or as	a consequer	nea off):							
been signed by the attending physi should be detached for use as the t	by Physician/Medic	in the past 12 1 Pes 2 (FEMALE: b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of pregnancy} \) 1 \(\subseteq \text{Ves}, \text{ outcome of death} \) 23c. If yes, outcome of pregnancy 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Ves}, \text{ outcome of death} \) 24 \(\subseteq \text{Pregnant at time of death} \) 25 \(\subseteq \text{Other} \(\subseteq \text{Subseteq} \) 26 \(\subseteq \text{Ves}, \text{Ves} \) 27 \(\subseteq \text{Ves} \) 28 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Unknown} \) 29 \(\subseteq \text{Unknown} \) 29 \(\subseteq \text{Ves} \) 27 \(\subseteq \text{Ves} \) 28 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 21 \(\subseteq \text{Ves} \) 22 \(\subseteq \text{Ves} \) 23 \(\subseteq \text{Ves} \) 24 \(\subseteq \text{Ves} \) 25 \(\subseteq \text{Ves} \) 26 \(\subseteq \text{Ves} \) 27 \(\subseteq \text{Ves} \) 27 \(\subseteq \text{Ves} \) 28 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 28 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 29 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 20 \(\subseteq \text{Ves} \) 21 \(\subseteq \text{Ves} \) 22 \(\subseteq \text{Ves} \) 23 \(Date of delivery Month Day Year		
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and	5 Pending investig. 6 Could n determine to the could n determine to the could n determine to the could need to the could	ation ot be ned 28e. Plus but a physician: To examiner: On the	fonth, Day 10/31 ace of Injuiting, etc. the best e basis of anner sta	y Year) 6 + Foury - At homic. (Specify) VG CA of my knowlef examination ated.	Injury MM d 10: e, farm, stre M f HC edge, death and/or inv	eet, factory, office USC occurred at the time estigation, in my of	Yes 2 No	Su 5 je 28f. L. ation (City or To 1116 Argyl	Street and Nun (Street and Nun wn, State) (2 A v e, B cause(s) and r date and place 29d. Date sign	haber or Rura office of State of Sta	G+5, ated. the car	Number,

State of Maryland / Department of Health and Mental Hygiene Reg. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 20, 2004 Muriel H Parry 0525 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Collington Life Care Nursing Home Prince Georges Mitchellville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2√2 F 579-60-3772 York Aug. 6, 1923 New Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is merked other then "neturel", or Items 23a or 28a-f show any injury or other traumatic event, I'me Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince Georges Mitchellville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10450 Lottsford Road 20721 **Unites States** Funeral . Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ØNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after of Hygiene. wher than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Surveyor Geological 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Elsie Hortel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reston, Virginia **Virginia 20191**20c. Location - City or Town, State Jacqueline Maschke Cousin 2406 Ansdel Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/04 Baltimore, Maryland Bayview Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funer Service Licensee Harman Funeral Service, P.A. 7221 Grayburn Drive, Glen Burnie, MD 21061 MOI113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician exarded Interestin Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 115.0050 þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has 1 Yes 24Kk 1 ☐ Yes 2 ☐ No or Attending Physician: efter death.

Diractor: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P 27. Mann of Death 1 Natural Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 2 🗆 No 1 Tes 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours er 1 Certifying Physician: To the best of my knowledge diath conumed at the time, date and plane, and due to the nause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) xuld-30. Name and address of person who completed can ext death (Item 23a) (Type, Print) Executive Place 1502 Lanham MD Jordo ablanamis mo 7404 oth, Day, Year)
0 8 2004 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygien 2 0 0 4 1 - For State Registrar 35290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Albert John Peters, Jr. <u>5:35</u> P ^M November 4, 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Manor Care Ruxton Towson Baltimore Co. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🛣 M 2 🗆 F Yrs. Director 76 217-24-0616 Sept. 11,1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner roust be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 21222 7971 St. Monica Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②CNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🔀 No þ Specify. 3 Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Press Operator Container Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert J. Peters, Sr. Anna M. Adams 19a. Informant's Name/Relationship (Type, Print) SOn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun Mr. Albert J. Peters, III Millers Island, Maryland 2811 7th Street 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 11/8/2004 Baltimore, Maryland ature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovas Cular Immediate Cause (Final Alter sclentic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a rostatic hypoplasic Examiner by the attending physician and tached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 🗆 🛵 1 Yes 2 1 Tyes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA tuneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 5 Pending death. 2 Accident 1 ☐ Yes 2 ☐ No investigation al or Attences after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 \(\text{Homicide} To the Hospital o 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) River Neck OBARTIO 201-109 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

			For State Registrar	State of Ma	-		nent of H		ind Me	-	giene		352	291
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	/Medic	al	Alvie Sylvester 4a. Facility Name (If not institution, give s	Price		4h	City, Town, or	Location of		Novemb		4, 2004 County of Dea		A ^M
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	yland now		10a. State 10b. County		10c. City, Town	or Location)						10d. Inside C	ity Limits
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	nd 2 s lith an 27 is i		Catherine P. Price				,					ryland		
Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23s or 28a-f ehow or other traumatic event, Ite Medical Examiner must be notified at		20a. Method of Disposition		20h Place of	Disposition	(Name of		Date			cation - City o		
im	Pages ment of I lant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		Park Memori			9,	, 2004	1			Mary1ar	
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	Sen-	es of Facility Pumphr ontgon	rey Funery A	neral	Hom Rocky	e/Rockville,	ville, : Md. 208	Inc. 50			
	*. 9		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each li	g, such as o	cardiac or re	espiratory ar	rrest,		Approximation Interval Bet Onset and	tween			
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Вох	death certificate be executed e attending physician and nd for use as the burial-transit	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death		pic pregnancy				2	23d. Date of de	•	Year
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	To the Hospital or within 24 hours affer To the Funeral Director completely filled in b	edical C	29a. Certifier 1 Certifying Physics (Check only one)		f examination an									s)
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	15×1		30. Name and address of person who co		death (Item 23a) 01 Munca			oad.	Rocky	ille.	Mary	71and 2	0855	
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	Registi	rar		JUT PAR	prise .	10	soon	6						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** ESSIE PRITCHARD /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat 4b. City, Town, or Location of Death Examiner CHEN ARMDER N32TH HOSPITAL DURNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. SEPT Day. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 911 1 M 200 93 SPRINGTON. WV Director 232-52-3740 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show in than "natural", or items 23e or 28a-1 showing the Medical Examinar must be notified ut Completed by Funeral Director 1 Yes XXNo ANNE ARUNDEL **PASADENA** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8010 CATHERINE AVENUE 21122 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XXo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: WHITE XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fi Health and Mental H tem 27 ts marked ot DAVID REED FANNIE FOLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH W. FERGUSON f Health POST OFFICE BOX 117 FRIENDSHIP, MD 20758 other 20b. Place of Disposition (Name of 20a. Method of Disposition

1XXSurial 2 □ Cremation 3 XXemoval from State 20c. Location - City or Town, State FERGUSON/WOOD CEM 11/6/2004 FLAT TOP, WV ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signar of uneral Service acensee FINK FUNERAL HOME, PA 22. Name and Address of Facility KELLY GREGORY FINK #MO1148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SPIRATOR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, negiguence of Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **Q**Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed: 2 No 1 🗌 Yes 2- No Division of Vital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and 2 certifier 29c. License number 29d. Date signed (Month, Day, Year) MD use of death (Item 23a) (Type, Print) and add ss of person who complete Eden Burnie MD 21661. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 8 2004 Registrar

		-	For State Registrer	State of N	Maryland / Dep <i>Ce</i>	artment c ertificate			nd Me		200	4	35293
	Physicia	an	1. Decedent's Name (First, Middle, Zebedee	Last)		Pier	Sor	л <i>I</i> II		2. Date of Death Month	Day 20	Year	3. Time of Death 06:25 M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numbe	r)	4b. City, Tov					4c. County	of Death	
			JOHNS HOPKIN	S HOSPITAL				ORE					
	Funeral Director		361-68-4735	3. Sex 7. A	40 Yrs.	Months D		f Under 2 Hours	Min.	3. Date of Birth (Month, Day, 1 5/23/196	(ear)	9. Birthi Cou	place (State or Foreign ntry)
	land land	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation.							10d. Inside City Limits
	Mary I-f sh	to	MD BALT	IMORE	OWINGS	MILLS							1 ☐ Yes 2 XX lo
	ith the	Sirec	10e. Street and Number			10f. Zip Co				10	g. Citizen of W		ntry?
	ath w	rail	4656 RIVERSTON				1117		:-0./0	- V N -		USA	can ledion
36	72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show cleal Everitres must be multified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces d 1 Tyes 2 If Yes, Give Year or Dates	XNo	Was Decedent If Yes, specify		anic Orig Mexican, Specify:	in? (Spec Puerto Ri	fy Yes or No- can, etc.)		c, White,	
Š	2 hou		15. Decedent's (Specify only highest		16a. Dec	edent's Usual O	occupatio	on ring most	of working	, 10	b, Kind of Bu	siness/In	ndustry
21215-0036	c * a	Completed	Elementary/Secondary (0-12)	College_(1-4o	r 5+)	DO NOT use n	retired)	-			EMULTO O		m A T
	filed within Hygiene. other then		12 17. Father's Name (First, Middle, L.	4	UI	PERATION				First, Middle, Ma	ENVIRO		IAL
Maryland		To Be	ZEBEDEE PIERSO	N, JR.			į	AU	DREY	J. MAYO			
Mar	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationshi NICHELLE PIERSO			-				Route Number, (T 202,	-		Z111/
	is 1 and Healing Healing	1	20a. Method of Disposition		20b. Place of Disp		of		Da		c. Location - 0		
OE .	00-		1 XXurial 2 □ Cremation : 1 □ Cremation : □ Other (Specific Control of Cont		NORTH	IPBES-66	RDE	NS	11/6/	2004	NORTH (CHIC	AGO, IL
Baltimore,	permit. Pag Department Important: I any injury o		21. Signat of Juneral Service	1:1		22. Name and A	Address o	of Facility	FI	NK FUNE , GLEN		_	
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	Physician		Immediate Cause (Final disease or condition			idosis							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of):								
Н	- Administra	-	Sequentially list conditions, if any, leading to immediate	b. ————————————————————————————————————	as a consequence of):								
	nted Insit	Examiner	Cause (Disease or injury	4									
<u>,</u>	ate be executed thysician and the burial-transit	Еха	that initiated events resulting in death) Last	CDue to (or a	as a consequence of):						-		
8760,	ysicia ysicia	edical		d									
9	diffical ng phi as th		IF FEMALE:	1									
D. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregr □ Other (specif					23d. Date Mon		ery Day Year
P.0	res that the de igned by the a be detached t		Part II. Other significant condition	s contributing to death	but not resulting in the	underlying caus	se given i	in Part I.		23e. Did toba	cco use contri	bute to t	he cause of death?
ds	puires n sign ald be	d by								1 ☐ Yes	2 No	3 🗌 Prot	oably 4 Unknown
Records,	0 = 0	Completed							_	24a. Was an autopsy performe	d? di	rior to co	opsy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26	6. Place	of Death (Check only one			
of V	\$ 5 D	To	1 ☐ Yes 2 No		atient 2 ER/Outpati			4 LI INUI		5 Residen			(y)
0			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 28b. Time Day Year) Injury		linjury at Work?			d. Describe how	injury occurre	ed	
Sio	Attending r death. sctor: After by the fune	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be	Injury - At home, farm, s	M Iront factors of		s 2 🗆 N		f Location /Stre	et and Numbe	r or Pur	al Route Number,
Division	2 in it	Certification:	4 Homicide determin		etc. (Specify)	пеет, гастогу, ог	IIICe		20	City or Town,		i oi riui	arriodic reamber,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C			st of my knowledge, dea of examination and/or stated.								
_	To th withir To th comp	Me	29b. Signature and title of certifier		2/ >	29c. L	icense n	umber		290	I. Date signed	(Month,	Day, Year)
J	,		Ignette Bro				5 -00				vember		
	h		30. Name and address of person w Lyncife Brown 31. Date filed (Month, Day, Year) NOV 0 8 20			e, Print)	10 N	Verth	Welfe				
		ate	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	1	11						
	Regist	rar	NOV 0 8 20	04 /22	0	sport.	2"						

Margaret Pleasant 04-7073

04-7073 AKG			For Unpend	Item	23a, 27,	zeman Zeman	yland / De	Pegane Pertifica	te of	lealth 05 ta	and N	Mental Hy	giene	004	35294
	Physicia	an	1. Decedent's Name (F	rst, Middle,					10 01 1	Deatri		2. Date of De	ath Day		3. Time of Death 8:14 A M
	/Medic Examin		4a. Facility Name (If not						, Town, o	r Location	of Death			County of Death	
		3	3111 Georg	getown	Road				altim					City	
995h	Funeral Director		5. Social Security Numb 215-12-373		5. Sex 1 ☐ M 2 💢 F	7. Age (li	n yrs. last birtho 7	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Aug • 2	7,19]	9. Birth Con L7 Mary	nplace (State or Foreign untry) y Land
	o		Usual Residence of De												
	show	ō	10a. State 10	b. County Cit	v	10	oc. City, Town o Balt	imore							10d. Inside City Limits 1 Yes 2 No
4	death with the Maryland ms 23a or 28a-f show Finust be fuelffied at	i Director	10e. Street and Numbe	r	etown Rd	l.			ip Code 2123	30			-	zen of What Cou	untry?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Both importent: If them 27 is marked other than "neturel; or leams 28 or 28a-f show any injury or other treumatic event, the Madical Examinating mast be rediffied at once.	y Funerai	11. Marital Status		If Yes, Gi	orces? 2 No ive	er in U.S.	13. Was Dec	ecify Cuba	lispanic Or an, Mexica Specify.	n, Puerto	pecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: [4]]	
2-00	72 hours neturel', lical Ext	eted by		Decedent's	Year or E Education grade completed)		16a. D	ecedent's Us	ual Occup	ation during mos	st of work	kina	16b. Kin	nd of Business/I	
2121	within riene.	Completed	Elementary/Seconda		College (Ti Vi	Give kind of w fe. DO NOT House		d)			Но	omemake	2
and	t be filed ntal Hyg ed othe event,	Be	17. Father's Name (First Melvi:							18. Moth		e (First, Middle herine			
aryla	should and Me s mark sumation	O_	19a. Informant's Name	/Relationshi	p (Type, Print)			-			er or Rui	ral Route Numb	er, City or	Town, State, Z	
Σ.	and 2 ealth a m 27 l				.easant -					Rock		, Westm		er, Md.	
Baltimore, Maryland 21215-0036	Pages 1 nent of H nnt: If ite nry or oth		20a. Method of Disposi 1 Burial 2 5 4 Donation 5	remation 3		1	20b. Place of D cemetery, Metro	crematory or	other place	Nov				cation - City or I imore, N	
Balti	permit. Departmingorie any inju		21. Signature	ervice Li	cansee &	4			ardt	Fune	ral	Chapel,			. Md. 21117
	Physician /Medical Examiner	ner	23a. Part f. Enter the canock, or heart fe indisease or condition resulting in death) Sequentially list condition from the cause. Enter Underlying to immediate such as the cause. Enter Underlying the short of the cause.	al ions, diate	Due to	iple (or as a c	e death. Do no injurie consequence of)	t enter the mo	de of dyir	ng, such as	s cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
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P.O. Box (the death certifica y the attending pl ached for use as t	hysician/Me	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	nths?		birth 2 (nant at tim	pregnancy □ Fetal death ne of death	3 □Ectopic 5 □ Other (У			2	23d. Date of deliment	very Day Year
ds, P	wrequires that the de been signed by the s should be detached	by P	Part II. Other significa	nt conditior	ns contributing to a	death but r	not resulting in t	he underlying	cause giv	en in Part	l.		tobacco us Yes 2 [the cause of death?
Division of Vital Records,	sicien: The law req : certificate has beer lrector, page 2 shou	Completed										24a. Was auto perfo		24b. Were au prior to death?	topsy findings available ompletion of cause of 2 No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Physicien: r this certifica ral director, I	o Be	25. Was case referred examiner? 1 [XYes 2 □ No		Hospital:	Inpatient	2 ER/Outp	atient 3 1	OA Dt			th <i>(Check only c</i> ome 5 ☐ Resi		XXXither (Spec	at scene
Jo (g Phy er this neral c	\vdash	27. Manner of Death		28a Date		28h Tir		28c. Injur			28d. Describe			.,,
io	ttending f death. ctor: After / the funer	catic	2 Accident	Pending 5 5 5 5 5 5 5 5 5	11-	2-04		М	10	Yes 2X]No			l down s	
Divis	or A fter Dire in by	Certification:	3 🗍 Suicide 4 🗍 Homicide	determin	200, Flat	ding, etc. (r - At home, fam (Specify)	n, street, facto	ery, office			City or To	wn, State)	3111 Ge	ral Route Number, eorgetown Rd
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier 1[(Check only 2]	Certifying Medical E	Physician: To the xaminer: On the land mai	ne best of r basis of ex nner state	xamination and/	death occurre or investigation	d at the ti	me, date a opinion, de	nd place, ath occur	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	ro the vithin ?	Me	29b. Signaruse and title	of certifier	0		-	2	9c. Licens	se number			29d. Date	e signed (Month	, Day, Year)
	,- > P 0		1/	by	repli				O.C.M	1.E.		1	Novem	iber 3,	2004
			30. Name and address	of person v	who completed cau	I M	th (Item 23a) (T		1 Per	n_St	reet	. Baltir	nore.	Marvla	and 21201
	Sta Registi		31. Date filed (Month,		8 2004	Registrar	Signature	-						4	

Roger Pleasant 04-7074 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		= State Unpend Item			Cel	rilica	ie oi L	Jean		3	2004	3529
Physician		Decedent's Name (First, Middle, Last	st)						2. Date of I Month		ay Year	3. Time of Death
/Medical		Roger Denn		t							2, 2004	8:14 A
Examiner	r	4a. Facility Name (If not institution, give				4b. City	, Town, or	Location of Dear	th	4	tc. County of Dea	ath
	4	3111 Georgetown R			- 4 5 1 4 5 - 1		timor				City	
Funeral Director		220-7. 5500	ex 7. Age ∏M 2□F	54	ast birthday) Yrs.	Months	Days	If Under 24 Hrs Hours Min	8. Date of E (Month, I Sept.	lirth Day, Yea 12,	9. Bi	rthplace (State or Fore country) aryland
DC .	h	Usual Residence of Decedent 10a. State 10b. County		10c Cib	, Town or Lo	ention						
ms 23a or 28e-f show ms 23a or 28e-f show must be notified at	- 1	Md. City		-	altimo							10d. Inside City Lim
s or 28e-f si	9	10e. Street and Number				10f. Zi	p Code			10g. C	Citizen of What C	ountry?
23a o	<u>a</u>	3111 Geo	rgetown Rd	•			212	30			U.S.A.	
r Items 23s	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13.	Was Dece	dent of His	spanic Origin? (S	Specify Yes or I	10-	14. Race - Am Black, Whi	
, - d	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Oivorced	1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates:	0		1 ☐ Yes		Specify:	to riisari, story		Specify: W	
natur cal	De l	15. Decedent's Ec	lucation		16a. Deced	dent's Usu	al Occupa	tion uring most of wo	diag	16b.	Kind of Business	/Industry
al Hygiene. Lother than "naturvent, the Medical Se Completed		Elementary/Secondary (0-12)	College (1-4or 5+	-)		Roof		uring most or wo	nxing		Construc	ation
tygie nt, m	3	17. Father's Name (First, Middle, Last)				11001	<u></u>	18. Mother's Na	mo /Eint Midd			
Mental H arked ott atic even	ם	Emmett Ple							aret Sa		en Sumame)	
\$ 2 E E	-	19a. Informant's Name/Relationship (Kenneth R. Pleas		her	19b. Mailir 117 H	ng Address IOIIO	s (Street a	nd Number or Rick Ave.,	Westmi	ber, City	or Town, State,	Zip Code) 21157
of Health a of Health a fitem 27 is	1	20a. Method of Disposition		20b. Pl	ace of Dispo emetery, cren	sition (Na	me of		Date		Location - City or	
rage nent o int: If iry or		1 ☐ Burial 2 ሺ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State ')		tro Cr			Nov. 6	, 2004	Bal	timore,	Md.
Department of I		21. Signature of Funeral Service Licen	of of		22 Ec	. Name a	nd Address	s of Facility ineral C	hapel,	P.A.		
	+	23a. Part1. Enter the disease, or com	olications that caused t	the death	. Do not ent	.605 -	Reist	erstown	Rd., O	wing	s Mills.	Md. 2111 Approximate
		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	€.			, ,	,	,			Interval Between Onset and Death
hysician /Medical		disease or condition resulting in death)	Dilated			athy						
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		IF FEMALE:	23c. If yes, outcome o	f pregnar	201							
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cate has been signed by the attendir , page 2 should be detached for use Completed by Physician/N	2	Chronic obstructi	ve pulmona	ry d	isease)			1 🗆	Yes 2	2 □ No 3 □ Pi	obably 4 Unknow
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ate has page 2	5								↑ per	opsy formed? 2 \(\Bar \)	death?	
certificate rector, pag	ע	25. Was case referred to medical						26. Place of Dea	ath (Check only		105	2 NO
this certific al director,	5	examiner? 1XXYes 2 ☐ No	Hospital: 1 Inpatien	t 2 🗆 8	ER/Outpatien	t 3 DC	Othe	-			6 NOther (Spe	cify) at scene
After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		28c. Injury Work		28d. Describe			,,
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within 24 hours after death. To the Funeral Director: After t completely filled in by the funera Medical Certification:		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At hor	me, farm, stre	eet, factor	y, office		28f. Location City or To	(Street a	and Number or Ru te)	Iral Route Number,
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hin 24 hours at the Funerel mpletely filled	200	(Check only 2 Madical Exam	iner: On the basis of and manner state	examinati	ion and/or inv	estigation	i, in my opi	nion, death occu	rred at the time	, date ar	nd place, and due	to the cause(s)
들는 물	E	29b. Signature and title of certifier	0			296	c. License	number		29d. Da	ate signed (Mont	h, Day, Year)
3 F 8		Y / (1D)	l'anu	>		0.	C.M.	E.		Nove	ember 3,	2004
1 N												
7 V		30. Name and address of person who	completed cause of dea	ath (Item	23a) (Type, I	Print)						
To To Con	V	30 Name and address of person who	completed cause of dea	ath (Item	23a) (Type, I		Pen	n Street	. Ralti			and 2120

			1 - For State of Maryland / Depa	rtment of Health and M tificate of Death		gie 2 e 0 0	4 35296
	Physici		1. Decedent's Name (First, Middle, Last) Goldie S. Rust		2. Date of De Month	ath Day	Year AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) St. Agnes Hospital	4b. City, Town, or Location of Death Baltimore	NOVE	4c. County	of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir	v. Year)	n/a 9. Birthplace (State or Foreign Country)
	Director		402-28-5547 1		Jan 17	1922	Kentucky
	harylan I show	ō	10a. State10b. County10c. City, Town or LocMarylandBaltimoreArbutus	cation			10d. Inside City Limits 1 ☐ Yes 2√7 No
	th the Nor 28e-1	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of V	
	s 23a c	eral D	1113 Flamingo Drive	21227		United	
9036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other then "neturel", or items 23a or 28e-f show other treumetic event, the Medical Examinat must be notified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ☎ No	Vas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No Rican, etc.)		e - American Indian, k, White, etc. - White
21215-0036	in 72 h	Completed	(Specify only highest grade completed) (Give I	ent's Usual Occupation kind of work done during most of work OO NOT use retired)	ing	16b. Kind of Bu	isiness/Industry
1212	led with lygiene. her the			dit Manager			ail Sales
land	uld be fi Yental H rked otl	To Be	17. Father's Name (First, Middle, Last) Roscoe Stewart	18. Mother's Name Catl		<i>Maiden Sumam</i> Branham	e)
Maryland	12 shouh and Nand Nand Nand Nand Nand Nand Nand			g Address (Street and Number or Rura			
	of Healt item 2		20a. Method of Disposition 20b. Place of Dispos	Wrens Nest Road,	RICNMO Date		City or Town, State
Baltimore,	permit. Pages 'Depertment of the Importent: If ite any injury or ot once.		4 □ Donation 5 □ Other (Specify) Loudon Pa	ark Cemetery 11/6,			e, Maryland
Bal	permit. Dep. rtr. Importe any inju			Name and Address of Facility Hu 4107 Wilkens Avenu			Home, Inc. Maryland 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	large bowe			12 hours
- 4	Examiner	76	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	c stock			Iday
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	morardial	info	arct	4 days
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887		Medic	IF FEMALE:				
.o. Box	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date Mon	e of delivery oth Day Year
JO rds, P	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.			bute to the cause of death?
US T		Completed	Hypertension			rmed? de	vere autopsy findings available rior to completion of cause of eath?
Vita Vita	rsicien: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death 3 DOA Other: 4 Nursing Hor			(Caralle)
Jo L	ing Phy Viter thi	on: T	27. Mannar of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?		ow injury occurre	
Division	Attend r death sctor: / by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	M 1 ☐ Yes 2 ☐ No et, factory, office			or or Rural Route Number,
Di	urs afte		A (5,555)		City or Tow		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director, to	edical	29a. Certifier Certifying Physician: To the best of my knowledge, death (Check only 2 Midical Examiner: On the basis of examination and/or invione) and marner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the ded at the time, d	ause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To ti Vithi To ti comp	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed	(Month, Day, Year)
	α		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) 4/84-3	~1	Nover	mor zau
	\0	10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	BALTIMORE, MOZ	1229		
	Sta Registr	9 6	NOV 0 8 2004 Beneve &	Spark			

		,	1 - For State Registrar	State of M		id / Depa	artmei	nt of H			- '		9	ic.	250	07
			Decedent's Name (First, Middle, Last))							2. Date of Dea		יט ט	(201	43. Em 6	Death
	Physici: /Medic		Benjami	n F. Rome	er						Novembe			/ear)4	12:35	5 P M
	Examin		4a. Facility Name (If not institution, give	street and number,)		4b. City	, Town, or	Location o	f Death		4c	. County of	Death		_
			Raphael House					ckvil		2411==			ontgo		J	
H	Funeral Director		363-03-6127	X 7. A(97	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Feb. 17	y, Year)	07	Birthi Coul Mic	place (State ontry) higan	or Foreign
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or La	ocation							T	10d. Inside C	ity Limits
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	r 28a	rec	10e. Street and Number				10f. Z	ip Code				10g. Cit	izen of Wh	at Cou	ntry?	
	h with	Funerai Director	1515 Dunster Road	d				2	0854			Un	ited	Sta	tes	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces		.S. 13.	Was Dece	edent of Hi	ispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	-		Ameri White,	can Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: It itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant. It a Marical Examical results in tilling at another.	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:		i i			Specify:		,		Specify:		hite	
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ā	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Ty			1					<i>l Route Numbe</i> ., Layt					2
	1 and Healt am 2		Bruce F. Romer/ Sc 20a. Method of Disposition)II	20b. F	lace of Dispo cemetery, crer				0	ate		ocation - C			
2	Pages nent of it ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify))	emetery, crer od1awn			1.4	oven 200	ber 8,	Det	roit.	Mi	chigan	,
Baltimore,	nit. Prartme ortan injur		21. Signature of Funeral Service Licens		WO			-								
ä	Depar Impo any ir		Kul Ja		м00	198 Rc	bert 0 Wes	A. J	Pumphi teome	rey rv A	Funeral ve., Roc	Hor kvi	ne/Ro	ckvi MD 2	ille, 0850-28	Inc. 05
			23a. Part1. Enter the disease, or compl shock, of heart failure. List only of Immediate Cause (Final			h. Do not ent	ter the mo	de of dyin							Approximat Interval Bet Onset and	te tween Death
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687		dicai		d												
×	ding se as	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregna	ancy							23d. Date	of delive	er./	
P.O. Box	death a atter d for L	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □Live birth 4□Pregnant a			□Ectopic □ Other (s	pecify)					Month			Year
o.	t the c by the achec	hysi	9 Unknown	9□ Unknown							-		-			
S, F	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	þ	Part II. Other significant conditions con Ischemic Heart		but not res	sulting in the u	nderlying	cause give	en in Part I.						he cause of do bably 4 □!	
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o	Attanding Physician: The rideath. actor: After this certificate hiby the funeral director, page	H-	27. Manner of Death	28a. Date of Inj (Month, Da		ER/Outpatier 28b. Time o		28c. Injury	at at		28d. Describe h				Livin	g
on	nding lath. r: After e funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay rear)	Injury	М	Worl	(? Yes 2 □ N	No						
Division of Vital Records,	At ago	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	ijury - At h	ome, farm, str fy)	reet, facto	ry, office			28f. Location (S City or Tow			or Rura	al Route Num	ber,
	spital ours a naral (29a. Certifier 1∑ Certifying Phy	sician: To the best	t of my kno	wledge deat	h occurre	d at the tim	ne date and	d place a	and due to the	cause(s	and mann	ner as s	tated	
	To tha Hospital or At within 24 hours after d To tha Funaral Diract completely filled in by	Medicai	(Check only 2 Medical Exami one)		of examina											i)
	To tha I within 2. To tha I complet	Me	29b. Signature and title of certifier				29	c. License			ş				Day, Year)	
			huston	Look M.	0				D3183	9		Nov	ember	5,	2004	
	n		30. Name and address of person who co	ompleted cause of												
	1		Christopher C. Dur	nford, M.			st Mo	ntgo	nery A	Aven	ie, Roc	kvi]	lle, N	Mary	land 2	20850
	Sta Registi		31. Date filed (Month, Day, Year) 8, 2	004 32. Regis	rar's Signa	ature	1	por	h							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1tem#20b, perFH, C837, 11/8/04 TI
State of Maryland 7 Department of Health and Mental Hygienes 0.04

		4	For State	State of Maryland?	Department of F Certificate of			2004	35298
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate Of	Dealii	Reg. N	lo.	3. Time of Death
	Physicia		T . ' -	Ree	CA			ay Year — 2004	8:35 AM
	/Medic		4a. Facility Name (If not institution, give st.			or Location of Death		lc. County of Death	
	Examin	er	Manor Care Nur	_	Tows			Baltimor	e
	F		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday) If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9 Birthnia	ace (State or Foreign
	Funeral Director			M 2⊠F 85	Yrs. Months Days	Hours Min.	(Month, Day, Yea	18 County	
		-	Usual Residence of Decedent						
	how	.	10a. State 10b. County	10c. City, Tow	n or Location			10	d. Inside City Limits 1 ☐ Yes 2 No
	e Ma	cto	MD Baltim	ore To	wson				
	ih th	Oire	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Count	ry?
	ath w	īa.	111 West Road			204	- Yes of No	U.S.A.	n Indian
	tems	Funeral Director	11. Markar Status	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 272No	13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, White, e	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married **Moved 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify: B1	ack
Ş	hour tural	edit	15. Decedent's Educ		. Decedent's Usual Occup	pation	16b.	Kind of Business/Inde	ustry
<u></u>	In 72	plet	(Specify only highest grade		(Give kind of work done life. DO NOT use retire	during most of worki d)	ng		
72	with piene.	Completed	12th grade	5yrs+	Nurse			Hospital	
ğ	othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	en Surname)	
<u>a</u>	Ald be Ald be riked riked tic ex	To E	Walter Hooper			Mary Ho	oper		
ary	should be seen and be seen as many seen as m	a	19a. Informant's Name/Relationship (Typ	e, Print) 19	b. Mailing Address (Street	and Number or Rura	I Route Number, Cit	y or Town, State, Zip (Code)
Σ	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "netural", or ftems 23a or 28a-f show ritem 27 is marked other than "netural", or ftems 23a or 28a-f show other traumatic event, the Medical Erammer must be multiped at	1	Mary Douthit-Gua		31 Madiso	n Ave, B	altimore	, Md 21	217
ore	of He		20a. Method of Disposition 1	moval from State	of Disposition (Name of ary, crematory or other pla		-2004	Location - City or Tov	
Ĕ	Pag ment ent: l		* 4 □Donation 5 □ Other (Specify)	Arbut	us Memori		1 1/8/0 4	Arbutus,	Md
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service License	* × 1	March F/	ess of Facility H West	n 1	0 F.M	1015
	₫ O E @ O		- Ellyno P	s- reke	4300 Wab	ash Ave,	Baltimo		1215
П			23a. Part. Enter the disease, or complic shock, or heart dure. List only on	ations that coused the death. Do	1 ' /	ing, such as cardiac c	i i espiratory arrest,		Approximate Interval Between Onset and Death
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н	/Medical Examiner		1	. Due to 'er as a consequence	of):			1	
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9	tificat ig phy as th	edi						1	
Box	leath certifica attending ph I for use as t	an/N	23b. Was decedent pregnant	lc. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	h 3⊡Ectopic pregnanc	Sy.		23d. Date of deliver Month	y Day Year
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P.0	at the de f by the stached	Physician/Me	9 Unknown Part II. Other significent conditions con		is the waderhies seven	won in Bort I	23e Did tobaco	o use contribute to the	a cause of death?
	res that igned be det	þ	Part II. Other significent conditions con	induting to death but not resulting	in the triderlying cause g	veitili Fait i.	1 ☐ Yes		ably 4 Unknown
of Vital Records,	w require been si should b	Completed					-		
ec	e law has b je 2 sl	npie					24a. Was an autopsy performed	prior to con	sy findings available opletion of cause of
E H		S	Land to the second				1 ☐ Yes 2 ☐		21 NO
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		han	n Check onli one	a Flores (0-1-1)	
of	di is	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2 ER/C	Outpatient 3 DOA Time of 28c. Inju	4 Z Is at sing no	me 5 L Hesidence 28d. Describe how in	6 □Other (Specify)
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Division	l or Attending Ph after death. Director: After th	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory, office	,		and Number or Rural	Route Number,
Ö	after Dire	Certification;	4 Homicide	building, etc. (Specify)		Į.	City or Town, S.	ate)	
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Phys	sician: To the best of my knowled ter: On the basis of examination a	ge, death occurred at the	time, date and place,	and due to the cause	e(s) and manner as sta	ated.
	he Ho n 24 he Fu pletel	Medicai	(Check only 2 Medicel Exeminate)	and manner stated.					
	To 1 To 1	Σ	29b. Signature and title of certifier	106.5		Se number	4 1	Date signed (Month, L — 2, – © 4	vay, ital)
			, e - cy	Let D		54424			
	į.		30. Name and address of person who co	mpleted cause of death (Item 23a	(Type, Print)	11 to #200	Timon.	um, MD	21093
	`		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Corr Fars	WILL HA		1110	
	St Reaist	ate	MOVI O C 2004	6 2 4	1				

			For State - State Registrar	ate of Marylar		ment of H		lental Hy	giene Reg. No.2	104	35299
	Dhariai		Decedent's Name (First, Middle, Last)	-				2. Date of De		Year	3. Time of Death
	Physici /Medic		Kenneth Paul Schro					11-	04-	04	11:20ªM
	Examin	er	4a. Facility Name (If not institution, give street Franklin Square Hosp	ital Center		Rosedo	r Location of Death		Ba	ty of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs.		Onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da March 1	5,1934	9. Birtho Cour Mary I	lace (State or Foreign and
	yland iow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	y, Town or Locat	ion				1	0d. Inside City Limits
	ith the Marylan or 28a-f ahow e notified at	ctor	MD Baltimore	Ba	ltimore						1 □Yes 2 □XNo
2	death with the Maryland rms 23a or 28a-f ahow rimant be notified at	Funeral Director	10e. Street and Number 6 Dundee Court			10f. Zip Code 21220			10g. Citizen o		ntry?
ennet/	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural, or itams 23a or 28a-f ahov any injury or other traumatic event. If a Medical Eventient ment be rediffed at Once.	by	1 Never Married 2 Married 1	as Decedent Ever in U med Forces? XYes 2 □ No Yes, Give ear or Dates:		s Decedent of Hes, specify Cuba	lispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ace - Americ ack, White, ify: Whit	etc.
henne 21215-0036	ithin 72 h ie. ien "netu Medical	Completed	15. Decedent's Education (Specify only highest grade com		(Give kin life. DO		during most of work d)	ing	16b. Kind of		dustry
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(000) Maryland	ind 2 shou alth and M 27 is mai ir traumat		19a. Informant's Name/Relationship (Type, P Mr. Kenneth P. Schroen, Jr	•			and Number or Run ghts Avenue				-
Sch altimore,	ges 1 a t of He If itam or oths		20a. Method of Disposition 1	al from State	Place of Disposition	ory or other plac	ce)	Date	20c. Location		
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of	y Phya ar this eral dir	n: To	1 105 2 100	a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	3 DOA 28c. Injun	4 Linuising no	me 5 ☐ Resi 28d. Describe I			′)
ion	Attanding F death. ctor: After y the funera	atio	2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □No				
Division of Vital Records,	To the Hospital or Attanding Phyalcian: The I within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - At h building, etc. (Special	ome, farm, street (y)	factory, office		28f. Location (. City or To		ber or Rum	l Route Number,
	Hospi 24 hou Funar stely fill	Medicai	29a. Certifier 1 Certifying Physician (Check only one) 1 Medical Examiner:								
	within To the compli) Me	29b. Signature and title of certifier	->		29c. License	e number		29d. Date sign	ed (Month, I	Day, Year)
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12	71		30. Name and address of person who complete. Stylart Shinder 31. Date filed (Month, Day, Year)	ed cause of death (Item 9000F(a) 32. Registrar's Signal	nKlin Sq	uare Dri	ve Balti	more,	4/. 21	237	
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar 35300 Certificate of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Short November 2004 11:45AM Ruth E. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Heritage Meridian Eldercare Dunda1k Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2√€ F Director 213-16-9647 Nov. 30,1922 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "neturat", or items 23g or 28e-f ehow treumatic event, the Medical Exertiner must be notified at 1 Yes 2 No Dundalk Baltimore Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code filed within 72 hours after death with 21222 1224 Willow Road United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than *ne any injury or other treumatic event, If a Medic 9058. College (1-4or 5+) Elementary/Secondary (0-12) Distillery 7 Years Line worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Elshire ပ္ Jacob Issac Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7712 Wynbrook Road Baltimore, Maryland 21224 Marie E. Rayner / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) 11/8/2004 Baltimore, Maryland Oak Lawn Cemetery 21. Signa ve of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death VAGINAL BLEEDING Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for a in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Onknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 NO To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Director: After that in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours are.
To the Funerel Dir 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print Play Dicadal MD 2 lea 32. Registrar's Signature State NOV 0 8 2004 Registrar

ysician ledical aminer	Decedent's Name (First, Middle, L Franklin Anthony Spe						2. Date of Deat Month	Day Year	3. Time of Dea
anniner	Flankini financing op			4b. City.	Town, or Loc	ation of Deetl		4c. County of Dee	th Orop
	Maryland Gre	neral Ho	spital	Balt	Limore	e Cr	Lef	,	
eral		5. Sex 7. Age (In yrs. last birthda	Months		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	thplace (State or Fo
tor	214-86-5509 Usuel Residence of Decedent		39 Yrs	.]			02-04-196	ob Mary	land
	10a. State 10b. County	1	IOc. City, Town or	Location		·			10d. Inside City Li
ţo	MD NA	1	Balt:	imore					1 AYes 2 □
Director	10e. Street and Number			10f. Zip	Code		1	0g. Citizen of What Co	ountry?
					216			US	
Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 No	er in U.S.	 Was Deceded If Yes, spec 	ent of Hispan ify Cuban, M	nic Origin? (S exican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Sp	pecify:		Specify: B1	ack
Completed	15. Decedent's (Specify only highest g	Education		cedent's Usua			ting	16b. Kind of Business	
nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life	ive kind of won DO NOT us Con	e retired) itation	y most or wor	King		
				Jail.				Baltimore	County
Be		.st)			18.		ne <i>(First, Middl</i> e, A eatrice Ric		
ြင	Henry Spencer 19a. Informant's Name/Relationship	(Type Print)	19h M	ailing Address	/Street and A			City or Town, State, 2	Zin Codo)
1	Beatrice L. Spencer/						, MD 21216	City of Town, State, 2	zip Code)
	20a. Method of Disposition		20b. Place of Dis		e of		and the same	20c. Location - City or	Town, State
	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Mt. Zion		rier place)	11-11	-04	Baltimore,	MD
	21. Signature of Juneral Servic Lic			22. Name and	d Address of	Facility			
	May register	11/1/1/1/	-	Wylie Fu	neral Ho	ome 638	N. Gilmor S	St. Baltimore	, MD 21217
al Examin		Due to (or as a c	consequence of):		Ca	colH	dela	und	
edical		71110111			CERT	IFICATION APP	ROVED BY MEDICA	EXAMINER	
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 [4□Pregnant at tim 9□Unknown	Fetal death	3 □Ectopic pre 5 □ Other (spe				23d. Date of deli Month	ivery Day Yea
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	25. Was case referred to medical				1 -	Place of Dea		1 Yes	completion of caus
To Be Completed by	25. Was case referred to medical examiner?	Hospital: 1 Vir atient			A Other: 4		1 ☐ Yes 2 th Check on one ome 5 ☐ Reside	1 ☐ Yes nce 6 ☐ Other (Spec	ompletion of caus 2□ No
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ertification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 25. Was case referred to medical examine 5 Pending investigate 10. Could not determine	28a. Place of Injury (Month, Day Y March 13,1 28e. Place of Injury building, etc. (Found: S	28b. Time Injur 4:00 At home, farm, (Specify) treet my knowledge 3 samination and/or	p of y P o M 28 street, factory, at become a investigation.	A Other: 4 Bc. Injury at Work? 1 Yes office	Nursing H 2 No 2 No	1 Yes 2 th Check on one ome 5 Resider 28d. Describe hor Subject 28f. Location (Str. City or Town, Lanvale and due to the da red at the time, da	nce 6 Other (Specwinjury occurred was shot. eat and Number or Ru State) Found: St., Baltim	empletion of cause 2 No cify) ral Route Nymber, 1526 W. ore, MD stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of All Copies Are Legible.

			1 = For State Registrar		arylanu / L	Certificate of	of Death		Re 2. Date of Deat	eg. No.	04	
Ph	ysicia	an	Decedent's Name (First, Middle, Last						Month	Day	Year	3. Time of Death
	Nedic		Kara-Lyn Eve 4a. Facility Name (If not institution, give			4b City Tow	n, or Location of	d Death	Nov.	4c. County	2004	6:15 a ^M
Ex	amin	er	814 Houcksville F			Hamps		, Dean			arrol	1.
Fun Dire	eral ctor		5. Social Security Number 6. S		e (In yrs. last birt		ar If Under 2	24 Hrs. Min.	B. Date of Birth Feb.		9. Birthp	lace (State or Foreign
ъ .	927		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	Od Incido City Limita
anyia •hov	9	_	Maryland Carroll			pstead					'	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	1	ect	10e. Street and Number	•	11011	10f. Zip Cod			1.	0g. Citizen of	What Coun	
ath with	val be r	Funeral Director	814 Houcksville			2	21074			U.S	.A.	
Id yid ILV 2.12.13-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show	xaminer	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 2 If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify C		gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		ce - Americ ck, White, by: Wh	
2 hou	7	ted	15. Decedent's Ed	lucation	16a.	Decedent's Usual Oc	cupation	-44:-		16b. Kind of B	lusiness/Inc	lustry
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y ould Men Men	atic	ှင	Scott Andrew Sc						nn Vano			
, Michal and 2 sh saith and n 27 is m	er traun		19a. Informant's Name/Relationship (Scott Schiller —		81	Mailing Address (Str. 4 Houcksv:	ille Rd.					Code)
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Daltillio permit. Pages Department of Importent: If it	eny inju		21. Signature of Funeral Service Licer	see A	,	Eckhardt 3296 Char	dress of Facility Funera	1 Cha	pel P.A	A. Md	21102	
	56.		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each li	i the death. Do r	ot enter the mode of	tying, such as o	cardiac or	respiratory arre	est,	21102	Approximate Interval Between Onset and Death
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UIVISION OI VILAI MEG To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has	d in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	9 29a Disea of Ini	ury - At home, fai c. (Specify)	m, street, factory, offi	C8	28	8f. Location (Str. City or Town	reet and Numb , State)	per or Rural	Route Number,
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5			30. Name and address of person who Amy McKee, M		leath (Item 23a) (Type, Print) St. CMSC (300 Ba	ultor	nore !	UD 20	0892	2
Be	Sta		31. Date filed (Month, Day, Year)		ar's Signature	Sour	2					

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		Examir		4a. Facility Name (If not	institution, give	street and num	ber)		4b. City, Town,	or Location of Death	THOVE	4c. County		111:39A.
0	0			340 ELMCROI					ROCKVII			MONTGO		
Y		Funeral Director		5. Social Security Number 176–62–5460	1 (x □M 2XIF	7. Age (In yrs. 29	last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Bir (Month, Da Sept.	th ly, Year) 9, 1975]	9. Birthp Cour Penns	olace (State or Foreign ntry) sylvania
		land ow		Usual Residence of Dec 10a. State 10b	. County		10c. Ci	ty, Town or Lo	cation				1	Od. Inside City Limits
		ath with the Marylan s 23a or 28a-f show	tor	Maryland :	Montgom	ery			Rockvill	e				1⊠Yes 2□No
		th the	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of W	√hat Cour	ntry?
		death with the Maryland ms 23a or 28a-f show rr ast be rectified at	ral	340 Elmero	ft Blvd				208			United	Sta	tes
	36	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a and righty or other traumatic event, If a Musical Exercities I assignee.	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 🔀		12. Was Deced Armed Ford 1 Tes : If Yes, Give Year or Da	ces? 2 [X]No 9		Vas Decedent ot f Yes, specify Cu l □ Yes 2፟፟፟ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Blaci	k, White,	ean Indian, etc. hite
	8	2 hour			Decedent's Edi		165.	16a. Dece	ient's Usual Occu	pation		16b. Kind of Bu		
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	21	ed wit ygiene yar th	Con			4		Admin	nistrati	ve Assista		Financi		ervices
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	2	hould d Mer marks matic	2	Robert P				10h Mailir	Address (Street	Annette	M. Lic		Ct-t- 7:-	0.4-1
		Ith an 27 is i		Annette M.										vania 15601
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		To the Hospital or Attending F within 24 hours atter death. To the Funaral Director: After completely filled in by the funer.	Med	one) 29b. Signature and title		and manne	stated.			se number		29d. Date signed		
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				30. Name and address of	ot person who co	ompleted onese	of death (Iten	n 23a) (Type, I		•11•1ú•		OVEMBER	4,20	JU 4
	_			THEVOORE					lll Penn	Street, I	Raltimor	m Marar	Land	21201
		Sta Registr		31. Date filed (Month, Da	X 0 8 21	32. Re	gietrar's Signa	ture 4	Spa.	1	ALCHINI	, ratty.	Late	21201
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State of Maryland / Department of Health and Mental Hygien 200 [35304 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 10:35A M OCTOBER 27. ALICE L. SEARS 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF NORTH ARUNDEL **GLEN BURNIE** ANNE ARUNDEL B. Date of Birth

(Month, Day Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Min. Davs Hours 1 🗆 M 85 MARYLAND 217-14-1385 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits s 23a or 28a-f show ANNE ARUNDEL SEVERN 1 Yes XXNo Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1578 RED HAVEN DRIVE 21144 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status event, the Medical Executivers permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Extrainer ance. Black, White, etc. 1 □ Yes 2 **X X**0 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specity: If Yes, Give WHITE ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE MARLOW EFFIE MARTIN ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 575 ST. MARYS AVENUE, GAMBRILLS, MD 21054 JOHN H.M. SEARS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXurial 2 Cremation 3 Removal from State GLEN HAVEN MEMORIAL 10/30/2004 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature at Lundra Scryico Lis nee 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 KELLY GREGORY KINK #M01148 23a. Part1. Enter the disease, or complic shock, or healt failure. List only one s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ie on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA Physician VEEK resulting in death) /Medical Due to (or as a consequence of): Examiner EMENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 2/ No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 XX of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: XXNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XXo ۵ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident in by the Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) INTERNALMEDICINE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 8 2004

			1 - State of M State of M Registrer	aryland / Depa	artment of Hea tificate of De	alth and Mental H	ygiene Reg. No.	004	35305
1	Physici	an	1. Decedent's Name (First, Middle, Last)	SIMP	SON	2. Date of D Month	leath Day	2 00 4	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc		4c. C	County of Death	10 10 1
	Europet		ST AGNES 5. Social Security Number 6. Sex 7. Ac	e (In yrs. last birthday)		IMORE Under 24 Hrs. 8. Date of B	irth	9. Birthn	lace (State or Foreign
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	with the	Funeral Director	10e. Street and Number 6350 Orchard Club Drive Apt	. 203	10f. Zip Code 21075		10g. Citize	en of What Cour Δ	ntry?
	ems 2:	ınera	11. Marital Status 12. Was Decedent Armed Forces:		1	nic Origin? (Specify Yes or N lexican, Puerto Rican, etc.)		1. Race - Americ Black, White,	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "neturel", or flems 23a or 28a-f show other treumatic event, the Madical Examinating the notified at	by FL	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	No	-	pecify:		Specify: Whi	
21215-0036	"netur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done durin	n g most of working	16b. Kind	d of Business/Inc	dustry
2121	filed within Hygiene. Ither than "	omp	Elementary/Secondary (0-12) College (1-4or		00 NDT use retired) visor of Bu	ilding & Grou	Heal	th Care	
pu	be filed tal Hyg d othe event.	Be	17. Father's Name (First, Middle, Last)		18.	Mother's Name (First, Middl	e, Maiden S	umame)	
Maryland	2 should be filed withing and Mental Hygiene. Is marked other than eumatic event, the Mental Comments and the Mental Comments	ပ္	Silas Edward Simpson, Sr. 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin		adie Mae Grove Numberor Rural Route Num		Town, State, Zip	Code)
	t and 2 : Health ar Iom 27 Is		Dorothy Simpson/Wife	6350	Orchard clu	b Drive Apt 2	•		
Jore	Pages 1 nent of He ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren Meadowrid	sition (Name of natory or other place) ge Memorial	Date		ation - City or To	
Baltimore,	- 5 # 5	1	`4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22	. Name and Address of	Facility		rid e, l	MD
ä	permii Depar Impor any ir	1	Dillung CLD	M I	328 Sulphur	eral Home, Inc Spring Rd. A	rbutu	s MD 21:	
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I Immediate Cause (Final	the death. Do not ent ne.			arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Living in death) a. Living in death Due to (or as	a consequence of):	L ME	MATOMA			DAY DAY
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9	The law requires that the death certificate be executed the has been signed by the attending physician and one 2s should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	,				Ì	
Box	death certifica e attending ph d for use as ti	ician/	1 Ves 2 No 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)		23	d. Date of delive Month	ny Day Year
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of Vital Records,	e law requii has been s je 2 should	Completed				24a. Wa	s an	24b. Were auto	osy findings available inpletion of cause of
al Re						peri 1 ☐ Yes	formed? 2 No	death?	22No
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	To th within To th comp	Me	29b. Signature and title of certifier		29c. License nur	mber	29d. Date	signed (Month, I	Day, Year)
	7		30. Name and address of person who completed cause of	leath (Item 23a) (Type	Print)	04	NO	Y . 00	.7004
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			For State Registrar	State of	Marylan		artment of F		nd Mental H	lygien Reg. No		35306
	0		1. Decedent's Name (First, Middle,	Last)					2. Date of	Death		3. Time of Death
	Physici		Morerr Constitution						Novem	Da hav 1	y Year	8:23PM
	/Medic Examin										. County of Death	
			Doctors Communi	tv Hospita	1		Lanham			Pı	rince Ge	orga!e
	Funeral			6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24		Birth		place (State or Foreign intry)
	Director		409-38-8784	1 ☐ M 2 🛛 F	75	Yrs.	Months Days	Hours	Min. (Month, Feb.	Day, Year) 13, 1	1929 Teni	ntry) Nessee
	pu ,		Usual Residence of Decedent		10- 00							
	aryta shov	-	10a. State 10b. County			, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	8e-f	cto		George's	Во	wie						
	vith th	Dire	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cou	intry?
	ath v	ra	11600 Trillum S			- 1	20721				ed State	
	er de Itam:	Funeral Director	11. Marital Status	12. Was Deced	ces?		Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No-	 Race - Amer Black, White 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 X Widowed 4 ☐ Divorced	ed 1 Tes : If Yes, Give Year or Da)		1 ☐ Yes 2 X DNo	Specify:			Specify: Bla	ck
21215-0036	72 hours after death with the Maryland Inaturel', or Itams 23s or 286-f show Acal Examiner must be invilled at	ed	15. Decedent'			16a. Dece	dent's Usual Occup	ation		16b K	(ind of Business/li	
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72	d within piene. r than "	E O	Elementary/Secondary (0-12)	College (1-	4015+)	Teach	er			Edu	ıcation	
ğ	illad Hygid other	a)	17. Father's Name (First, Middle, L		···········			18. Mother's	s Name (First, Midd			
Maryland	lid be fental rked o	To B	John Flanagan					Martha	a Owen			
ary	2 should and Men Is marke aumatic	_	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street		or Rural Route Nun	nber, City o	or Town, State, Zi	p Code)
	t and 2 Health a tem 27 ls		Pamela Liddell/	Daughter		50650	Tumb1ewe	eed Tra	ail, Gran	er.	IN 46530)
ē	s 1 a		20a. Method of Disposition		20b. Pi	lace of Dispo	sition (Name of		Date		ocation - City or T	
Ĕ	Page nt: If rry or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		St.	Josep orial	h Valley park	11	/9/2004	Gra	nger, IN	ī
Baltimore,	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Itams 23a or 28e-f show any injury or other traumatic avent, the Madral Examiner matter matter all once.		21. Signature of Funeral Service L	icensee	#CC03;		Name and Address	ss of Facility	0 m o	GIG	inger, in	1
m	Depa Impo any ir		Mancel	L. Boss	olle	25	28 Mishav	vaka Av	ve., Sout	h Ben	nd. TN 46	615
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9	ing pl	Med	IF FEMALE:								ļ	
Вох	death certifi e attending d for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outc	ome of pregnar th 2 ☐ Fetal		Ectopic pregnancy	,			23d. Date of deliv	*
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Ś	Se Do	by	Part II. Other significant condition	is contributing to dea	ath but not resu	ilting in the u	nderlying cause give	en in Part I.				he cause of death?
ord	w requir been si should	ted							1L]Yes 2≠	No 3 □ Pro	bably 4 Unknown
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<u>د</u>	Th ate pag	Con							pe 1 ☐ Yes	rfórmed?	death?	21 No
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of \	S S S	2	1 ☐ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nurs	ing Home 5 ☐ Re	sidence	6 □Other (Speci	(y)
		on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describ	e how injur	ry occurred	
sio	Attending r death. actor: After by the fune	catl	2 Accident investig	ation				Yes 2 □ No)			
Division	I or Atten after deat Diractor: I in by the	Certification:	3 Suicide 6 Could not determine	and Zoe. Place	of Injury - At ho g, etc. (Specify	me, farm, str)	eet, factory, office		28f. Location City or 7	(Street an own, State	nd Number or Rur. e)	al Route Number,
	urs a											
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier Certifying (Check only 2 Medical E	Physicien: To the li xaminer: On the ba and mann	sis of examinat	wiedge, death ion and/or in	n occurred at the time time time time. The comments of the com	ne, date and p pinion, death	place, and due to the occurred at the time	e cause(s) e, date and) and manner as s d place, and due t	tated. o the cause(s)
	o the ithin 2 o the	Mec	29b. Signature and title of certifier	and manin	Stated.		29c. License	e number		29d. Dat	te signed (Month,	Dav. Year)
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١.			30 Name Carlotte	MOU	V V	220) (5	Print)	200	_>		4/1/	my
1	10			No completed cause	Oldeath (Item	23a) (Type,	·	5,1, 77=	- / mise		1070-	7
	Sta	te.	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat	ure	155416	JULLE	LAURE	MO	1070	/
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State of Maryland / Department of Health and Mental Hygiens 35307 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** FLORENCE LOUISE WINANS NOVEMBER 9:05 A. /Medical 2004 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CLINTON SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2000 97 Yrs. 4/21/1907 Director 203-01-9315 PENNSYLVANIA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits oriant: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show injury or other traumatic event, Its Modical Examinar must be notified at 1 ☐ Yes 2 ☐ XNo Directo PRINCE GEORGE TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5635 FISHER ROAD by Funeral 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) PAPER PRODUCTS s 1 and 2 should be filed within f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING YEARS SALESPERSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES KITTLE ANNA WARNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY BELCHER 5635 FISHER ROAD DAUGHTER TEMPLE HILLS, MO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Dapartment of H
Important: If its
any injury or ot 1 Peurial 2 Cremation 3 Removal from State MORELAND MEM. PARK ' 4 ☐ Donation 5 ☐ Other (Specify) 11/9/2004 HILLENDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD and. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician SMALL cell LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Squamms الهي CArcinoma of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 the attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy be detached for Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 2 🗆 No 1 Yes 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 2 1 Minpatient within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Willia I dome an D35206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. TANNER MD Road fort wastington many has Livingstm 11701 31. Date filed (Month, Day, Year) NOV 0 8 2004 32. Registrar's Signature State sacker Registrar

			State of Maryland / Department of Health 1 - State	_	2006	35308
	° Physici	an	Decedent's Name (First, Middle, Last) A	2. Date of De	aath Day Year	3. Time of Death
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	yland iow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Man a-fsh	ctor	Maryland Anne Arundel Glen Burnie			1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	
	ns 23	eral	203 Third Ave., S.E. 21061 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C	Origin? (Specify Ves or N	United Sta	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avent, it a Madical Examitient must be notified at once.	by	If Yes, Give Year or Dates: WW II □ Yes 2⊠ No Special	ican, Puerto Rican, etc.)	Black, Whi	
21215-0036	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m	nost of working	16b. Kind of Business	/Industry
121	within ane. than	ldm	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Electrical Inspect		Federal G	overnment
d 2	illed Hygie other ent, II	Be Co		other's Name (First, Middle		Overiment
/lan	uld be Mental Irked Itic av	To B	Irvin Marion Wenzel Fre	eida Schmidt		
Maryland	12 sho and I		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num			
	1 and Healtl Iam 2		20a Method of Disposition 20h Place of Disposition (Name of	Date	20c. Location - City or	
ē	Pages nent of int: tf ii		1 X Aurial 2 Cramation 3 Removal from State 1 A Donation 5 Other (Specify) Clen Haven Mem. Park	November 6		e, Maryland
Baltimore,	permit. Departn Importa any inju		21. Signaturi of hundral Service icensee 22. Name and Address of Eac Kirkley-Ruddic 421 Crain Hwy.			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Death 4 ddy S
	Examiner		Due to (or as a consequence of):			/
	-fv :=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
Vi	secure and t-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dical E	d			7
9	tificate ng phys as the	Medic	0			
. Box	The law requires that the death certifics tie has been signed by the attending of page 2 should be detached for use as to	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of de Month	ivery Day Year
<u>о</u>	d by the	Phys	9 Unknown	00- 014		
Records,	w requires that been signed I should be det	ted by		1 D	obacco use contribute to	othe cause of death?
al Rec		Completed		24a. Was autop perio		topsy findings available completion of cause of 2000
Vital	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner? Hospital: Hospital: Other:	ace of Death Check onl o		
o	g Phys er this eral di	n: To	1 Inpatient 2 EN Outpatient 3 DOA 4	Nursing Home 5 Resid	dence 6 Other (Spe	cify)
ioi	Attanding Phy r death. ector: After thi by the funeral c	atlo	1X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐	□No		
Division of	4 - 6 6	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ral Route Number,
	To tha Hospital or within 24 hours afte to the Funaral Director Completely filled in the completely filled in the formula of the filled in the			and place, and due to the	Called(e) and massar =	stated
	n 24 h n 24 h ne Fur bletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	leath occurred at the time,	date and place, and due	to the cause(s)
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number	or .	29d. Date signed (Mont	Day, Year)
		,	My Surchez MD 177701		NOV 03 :	2004
	Q		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) And Smunet MD 22 South Greax Smelt Bath	more, MD	21201	
	Sta	te	31. Date filed (Month, Nat) Year 8 200 32. Register's Signature	mind (I'I)	XICU!	
N. S.	Registr	ar	31. Date filed (Month, NO Very 8 2004 32. Registrar's Signature	,		

State of Maryland / Department of Health and Mental Hygiene 35309 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician PM October 31. 2004 7:40 Lucy Morton Weidemeyer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🖾 F October 7, 1927 North Carolina Director 577-34-1617 Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d Inside City Limits 10a State 10b County ir than "natural", or items 23a or 28a-f show the Madical Expedient of the notified at 1⊠Yes 2□No Director Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 United States death v 614 Crocus Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. a filed within 72 hours after Il Hygiene. other then "natural", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 12 Secretary 18. Mother's Name (First, Middle, Maiden Surmame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Jury or other traumatic event 2008. Be ပ Joseph Morton Bessie Mae Rowles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24220 Hawkins Landing Drive, Laytonsville, MD 20882 Bill M. Weidemeyer / Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery November 4, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 2004 ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Juneral Service License M01405 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 Day disease or condition resulting in death) Bowel Necrosis /Medical Due to (or as a consequence of). Examiner 1 Day Sepsis Sequentially list conditions, harry, leaving to in recially cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nedormed 1 Yes 1 Yes 2× No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification; Injury at Work? After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hor To the Funs completely fi Medical (Check only one) and manner stated. 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and little of 949187 OCTOBER 2004 PKURUNUA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajit P. Kuruvilla, M.D. 11125 Rockville Pike, #208, Rockville, Maryland 20852 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiere 1 1

			1 - For State Registrar	State of Ma	Ce	artment of F rtificate of			eziel () ()	33310	
	Physici /Medic		Decedent's Name (First, Middle, Las LEO ANTHON	Y WHITEHA	AIR			2. Date of Death Month NOV	Day Year 2 2004	3. Time of Death 5:15	
	Examir Funeral	ier	4a. Facility Name (If not institution, give NATIONAL NAVAL M 5. Social Security Number 6. Se	EDICAL CE	NTER e (In yrs. last birthday)	BE1	Or Location of Death THESDA If Under 24 Hrs.	8. Date of Birth	4c. County of Death MONTGO 9. Birth		
	Director		509-34-2671 19 Usual Residence of Decedent	⊠ M 2□F	75 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) June 13,	1929 Kar	uintry) 1sas	
	Maryland f show	tor	10a. State 10b. County Maryland Montgome	ery	10c. City, Town or Lo	ckville		7-7-		10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	ath with the 23a or 28a ust be not!	rai Director	10e. Street and Number 707 Wilson Avenue			10f. Zip Code	850	g. Citizen of What Country? United States			
920	ours after desail, or Itams	by Funerai	11. Marital Status 1 ☐ Never Married 2∑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:]	10	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W		
Maryland 21215-0036	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumetic event, the Medicul Examinating the indifficulation. Once.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	1+)		oation during most of worki d) terinary M		National I of Health	nstitutes	
and 2	ld ba filed within antal Hygiene. ked other than ' ic event, Lrawe	To Be Co	17. Father's Name (First, Middle, Last) John Leo Whiteh		рпес	.01 01 VE	18. Mother's Name		aiden Sumame)	-	
	1 and 2 should Health and Man Health and Man em 27 is marke		19a. Informant's Name/Relationship (7 Gloria M. Whiteha			-			City or Town, State, Z	. ,	
Baltimore,	Pagas 1 a nent of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☑ Other (Specify	Removal from State PEntombment	20b. Place of Dispo cemetery, crer Gate of Mausol	sition (Name of matory or other place E Heaven eum	Novem	ber	oc. Location - City or 1	Town, State	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens	~	M00198 RC 30	Name and Addre bert A. O West Mon	ess of Facility Pumphrey l ntgomery A	Funeral H ve., Rock	Home/Rockv	ille. Inc.	
	Physician /Medical Examiner		23a. Part1. Entit the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. NON	the death. Do not ent ne. HODGKINS L a consequence of):		ng, such as cardiac o	r respiratory arres	it,	Approximate Interval Between Onset and Death	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
68760,	tificate be axecuted ig physician and as the burial-transit	edicai E		d	2 33/133443/103 31).						
.O. Box	death cer e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	/		23d. Date of deliving Month	very Day Year	
<u>α</u>	w requires that the been signad by th should be detache	by	Part II. Other significant conditions co	intributing to death bu	ut not resulting in the u	nderlying cause giv	ren in Part I.		cco use contribute to 2 \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	the cause of death?	
al Records,	The lay ate has page 2	Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of	
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No	Hospital:	nt 2 ☐ ER/Outpatien	t 3 DOA Oth	26. Place of Death		ce 6 □Other (Speci	iful	
ion of	Jing After fune	ation: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	28c. Injur Wor	y at 2	28d. Describe how		<i></i>	
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide defermined	building, etc				City or Town, S			
	the Hosp in 24 hou tha Fune poletely fil	ledicai	one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	ol my knowledge, death examination and/or inv ted.	vestigation, in my o	pinion, death occurre	and due to the caused at the time, date	se(s) and manner as s a and place, and due t	stated. o the cause(s)	
	or with	W	29b. Signature and ittle of certifier	ME	7		3518 (VA)			3 2004	
ì	19.		30. Name and address of person who could be with the BENNET' 31. Date filed (Month, Day, Year)	T LT M	eath (Item 23a) (Type, IC USN pr's Signature		NATIONAL N BETHESDA M		ICAL CENTE 5600	l'R	
	Sta	ιτe	NUV no		A A-A /	6 1					

State of Maryland / Department of Health and Mental Hygiene 0 0 4 35311 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Alberta West 1830 2004 November 4 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Augsburg Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
03 27 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2X F 85 Yre Director 218-18-1182 GÄ Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ne 23a or 28a-f sho must be notified at to 2 No Funerai Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 3411 Kelox Road U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. Ither than "natural, or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4yrs Disability Examiner Social Security Adm. 12th grade Peges 1 end 2 should be filed nent of Health end Mentel Hygi nt: If item 27 is marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hassie Miles James Willie West 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gladys West Watties-Sister 6903 Brompton Road, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: If 0 4 ☐ Donation 5 ☐ Other (Specify) 11/9/04 Baltimore, Md Woodlawn Cemetery 21. Signature of Funeral Service Licensee March For H West 21215 4300 Wabash Ave, Baltimore, 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 3 months . END STAGE ALZITETMEN DEMENTIA Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 MNo 1 ☐ Yes 2 PNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 Natural i efter death. Il Diractor: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital or within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 445931 November 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANICHEIGHTS AVENUE BAZTIMONE MD ZIZOS 7220 I 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Yea ERNEST WRIGHT 19:13 October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION MEMORIAL BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 09/23/1936 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 SC 1 M M 2 □ F 212-32-5488 68 Director Yrs. Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Director MD 1 Yes 2 □ No N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 222 N. MOUNT STREET 21223 Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 22 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LANDSCAPING LANDSCAPING 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IKE WRIGHT MARTHA MARINEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau <u>once</u>. ERNESTINE WRIGHT/WIFE 222 N. MOUNT STREET, BALTO., MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ZION CEMETERY 11/06/04 ^¹ 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.R., INC 21. Signature of Funeral Service Licensee 1701 LAURENS STREET, BALTO., MD 21217 23a. Part . Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Infarction occardial Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 X No 1 🗌 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a To the Funeral D filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) Marsa Manelstash, MD AT 243 8946 October 31,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorical Hospital 201 E. University PKWY, Baltimore, MD 21218 Mohebtash 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 NOV 0 8 Registrar

Amend item#5, per, FH, G837, 11/1//04 TT

State of Maryland / Department of Health and Mental Hygie 1.

State of Maryland / Department of Health and Mental Hygie 2.

1. For Amend Item 23a per Dr., G837, 11/05/04dhb Death

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 2.0 14

Registrar 35313 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day /Medical Rebecca Warshawsky September 28 2004 4c. County of Death 2:30p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Mont gomery

9. Birthplace (State or Foreign Country) 8. Date of Birth
(Month, Day, Year)
Jan. 8, 1916 215 50 2300 215 50 2300 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Days 1 ☐ M 2 ☐ F Hours 88 Director Pennsylvania Usual Residence of Decedent 10b. County show 10c. City, Town or Location 7 is marked othar than "natural", or itams 23a or 28a-f shov traumatic evant, the Medical Evantrar must be rottfied at 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 North Leisure World Blvd. #516 14. Race - American Indian, Black, White, etc. 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIIIo Specify: White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Self Employed Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental Morris Greenblat ပ Jenny Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any Injury or othar trai once. Louis Warshawsky_/ Husband 3330 North Liesure World Blvd. #516 Sil Spr,MD20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State King David Cemetery 10/3/2004 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service 11800 New Hampshire Ave Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Anoxic Focephalapathy Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last physician ar Due to (or as a consequence of) Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy this certificate 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ō 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28d. Describe how injury occurred To the Hospital or Attanding Division 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hrspital Sobusta 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2004 MIN THE Registrar

Warshawsky

		4 Decedent's Name (First Add)	Lant		Certif	icate of	Dealli	2. Date of Death	g. No	nl.	2521
ysicia		1. Decedent's Name (First, Middle, Last) Grace Ellen Yingling						Month	3-2	Xear W	Time of Death
Medica amine		4a. Facility Name (If not institution,			4b. City, Town, or			ocation of Death	4c. County	of Death	7.00
annic		Long View Nurs	sing Home		Manches		ster		Carro	011	
eral ctor		5. Social Security Number 213–16–1407	6. Sex 7 1 □ M 2 ☑ F	. Age <i>(In yrs.</i> 93	Me	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep 8,	Year) 1911		ace (State or Fore ry) /land
	Ì	Usual Residence of Decedent		10.0							
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	오上	Maryland Cat 10e. Street and Number				Of. Zip Code	Mariches		og. Citizen of	M/hat Causts	
	ੂ	3279 Charmil D	rive		'	oi. Zip Code	21102		og. Onizen or	USA	y.
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	ğ	15. Decedent's (Specify only highest	s Education		16a. Decedent's	s Usual Occup	pation during most of world)	kina 1	6b. Kind of B	usiness/Indu	ıstry
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<u>.</u>	င်္ခ	9			Caf	eteria	Worker				
	m	17. Father's Name (First, Middle, L	.ast)					ne (First, Middle, M Hybeck	<i>laiden Sum</i> an	ne)	
F	0	Mathias Lang 19a. Informant's Name/Relationsh	in (Type Print)		19h Mailing As	Idraes (Street	end Number or Ru		City or Town	State 7in C	Code
17	1	Ethel Hooper,					Drive, N				,ode)
i	ŀ	20a. Method of Disposition		20b. F	Place of Disposition	/Name of		Date 2	Oc. Location -		n, State
any injury or other traumatic event, the Medical Examiner must be notified at once. To Do Commission In the Commission of the Commission		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		ate	emetery, cremator nydersbur		' 1-	L1/06 2004	Hamps	tead,	MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1.3 per MD C837 11/8/04TT
State of Maryland / Department of Health and Mental Hygien@ () () ()

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Dorothy Zaukus** Opin Death **Physician** Month Year -auto 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis, Md Medical Center Inne Trade If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 8, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-32-3959 1 ☐ M 2 🖳 F 69 Maryland Yrs. Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ahov The Medical Executive regist be notified at Director Maryland Anne Arundel Queenstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Wick Court 21658 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If itam 27 is markad other th jury or other traumatic evant. Its Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George White Dorothy E. Amoss ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony F. Zaukus Sr. - Husband 118 Wick Court Queenstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 Aurial 2 Cremation 3 Removal from State Department of Important: If any injury or Lakemont Mem. Gardens 10, 2004 4 □ Denation 5 □ Other (Specify) Davidsonville, Maryland Fun tal Service Licensee Kirkiey-Ruddick Funeral Home P.A. 21061 0 421 Crain Highway S.E. Glen Burnie, Maryland 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician GII 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ίó in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 00 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA patient this 27. Manner of Lath De of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending after death. death. 1 ☐ Yes 2 ☐ No investigation in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10057985 MUL 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) 888 HORTON.M BESTGATE RD STE 21 , ANNABOUS, NO 2140 31. Date filed (Month, Day, Year) NOV 0 8 2004 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2004 35316 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** 2-10 AM AUSHERMAN M HILDA 10 2004 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Harford Upper Chesapeake Medical Ctr Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□ M XXF 79 Mary Land 215-14-1313 Yrs. Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Energia at mast be neithed at once. 10a. State Maryland Harford Joppatown 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21085 402 Latimore Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (Clem Ausherman Goldie Earl Edgar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LuRay Ausherman/Brother 193 Sunbrook Lane, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State Reformed Cemetery Nov 3, 2004 Middletown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

W00706

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home

106 East Church St, Frederick, Maryland 21701

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final) Approximate Interval Between Immediate Cause (Final disease or condition ASPIRATION PNEUMONIA 30 HRS Physician resulting in death) /Medical Due to (or as a consequence of): CAREBRAL VASCULAR ACCIDENT **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MASS CHEST 2 ₽No 3 Probably 4 □Unknown ITYPO THER MIA 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No funeral director, page 2 SEVERE PEDTIC ULCER DISEASE 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in hours. 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/30/2004 D21207 ATTENDINE PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VELLA-CAMILLERI, M.D. 5 MIDCREST COORT, BALTIMORE MD 21286 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

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MR#169

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P.O. I

Division of Vital Records,

DHMH 17 Rev 1/2001

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		-	For Amend Item #8 State of Maryland / Dep = State WCHD/SH 11/1/04 per FH Ce	artment of Health and M rtificate of Death	ental Hygien 2 (004 35317
	Division		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic	al	GLENN ARNOLD BOWMAN SR.		OCTOBER 27,	2004 1935 M
	Examin	er	4a. Fecility Name (If not institution, give street and number) 10 PARK VIEW	4b. City, Town, or Location of Death BOONSBORO		unty of Death WASHINGTON
	Funeral Director		5. Social Security Number $219-20-2613$ 6. Sex $1 \boxtimes M$ $2 \square F$ 7. Age (In yrs. last birthday Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 5 (Month, Day, 197) 2 MAY 27, 199	9. Birthplace (State or Foreign Country) MARYLAND
	and w	-	Usual Residence of Decedent 10c. City, Town or L 10a. State 10b. County 10c. City, Town or L	ocation .		10d. Inside City Limits
	Mary fied a	to	MARYLAND WASHINGTON	BOONSBORO		1 Yes 2 □ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?
	23a c	ain	10 PARK VIEW	21713		U.S.A.
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene, dit hygiene, dit other than "netural", or items 23a or 28a-f show do other than "netural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Ammed Forces? 1952-1 Yes, Give Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Race - American Indian, Black, White, etc. ecity: WHTTE
9	72 hou netura			dent's Usual Occupation skind of work done during most of working	16b. Kind	of Business/Industry
21215-0036	within 7 lene. than "n the Med	Completed		DO NOT use retired)	,,,g	
12	filed w Hygier ther the		8 17. Father's Name (First, Middle, Last)	TRUCK DRIVER	TRUC	CKING COMPANY
Maryland	d be f	To Be	FLOYD NELSON BOWMAN	111	NE OLIVE SHII	
ary	2 should be and Mental I is marked o	F		ing Address (Street and Number or Rura		
	ss 1 and 2 should of Health and Mer item 27 is marke r other treumatic			PARK VIEW, BOONSBO		
Baltimore,			1 XBurial 2 Cremation 3 Hemoval from State	matory or other place)		ion - City or Town, State
ij	t. Pag rtmen rtent: njury	1		RO CEMETERY 10/30, 2. Name and Address of Facility		SBORO, MARYLAND
Ba	permit. Page Department of Importent: If any injury or once.		Paul M. Dean	BAST FUNERAL HOME	7606 OLD NAT BOONSBORO, M	
			23a. Pert 1 Enter the disease, or complications that caused the leath. Do not en shock, or heart failure. List only one cause on each line	ter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
H	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	g canc	cc.	31 months
П	Examiner		Due to (or as a consequence of):	0		
		ner	Sequentially list conditions, if any, leading to immediate cause. Fast illocation in Cause (Disease or injury)			
	acuted ind transil	Exami	that initiated events c.			
8760,	cale be executed physician and the burial-transit	aj Ex	resulting in death) Last Due to (or as a consequence of):			
687	ficate physis the	edicai	d			
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d	. Date of delivery Month D <i>a</i> y Year
	ires that signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
örö	w requir been si should	eted				4b. Were autopsy findings available
Vital Records,	The law cate has page 2 s	Completed			autopsy performed?	prior to completion of cause of death? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)
ital		BeC	25. Was case referred to medical examiner?	26. Place of Death		
of V	Physicien: this certific ral director,	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			
ou c		ion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury or	ccurred
Division	ii or Attendii after death. I Director: A d in by the fu	ficat	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm, s		28f. Location (Street and N	lumber or Rural Route Number,
ă	tal or A	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.			
ı	To the To the comp	M	29b. Signature and title of certifier	29c. License number	29d. Date si	igned (Month, Day, Year)
	4-1241		30, Name and address of person who completed cause of death (Item 23a) (Type	, Print)	ilan	21740
	7		31. Date filed (Montto Day Year) 32. Aggistrar's Signature	30 UPAL (10, Mag	EISTOWN, MI)
	Sta Registr		31. Date filed (Month 22 Year) 2004 32. Registrar's Signature	Locale d		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 1 35318 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 25° 2004° Margaret Ruth Baker 7:10 PM_M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death Examiner 4c. County of Death Citizens Nursing Home Frederick Frederick Months Days Hours Min. Dec. 9, 1917 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 216-70-0007 1 ☐ M 2 🗓 F 86 Director Vrs Marvland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatith and Mental Hygiene.
ant: If item 27 is marked othar than "natural", or Items 23a or 28a-f ahov ury or other traumatic evant, the Medical Examination and Item and Item and Item and Item and Item. or 28a-f ahow 10d. Inside City Limits Frederick Maryland Adamstown Director 1 ☐ Yes 🏖 No 10e. Street and Number 10f. Zip Code 21710 10g. Citizen of What Country? 5032 Doubs Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 反 No Completed by 3 X Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vernon Etzler Ethel Irene Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Betty L. Wilcom, Daughter 11508 C Fingerboard Rd., Monrovia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If any injury or once. Resthaven Memorial Gardens Nov. 3, 2004 | Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. NReemey and Basford PA Funeral Home uchand M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Conlin Versento Slain **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last or Attanding Phyaician: The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No Completed 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 25 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) ner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To tha Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certile 0 -15711 11/1/04 41 St. Frederick, 14d 21701

Registrar DHMH 17 Rev 1/2001

State

Name and a dress of person who co

NOV 0 8 2004

31. Date filed (Month, Day, Year)

se of death (Item 23a) (Type, Print)

A sistrar's Signature

1. Decedent's Name (First, Middle, Last) Robert James Lee Burdette Robert James Lee Burdette 4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL Funeral Director Funeral Director Physician (Medical Examiner) Funeral Director Funeral Director Physician (Medical Examiner) Funeral Director Funeral Director Funeral Director Physician (Medical Examiner) Funeral Director Funer	The Day Year 3. Time of Death 9:49p M 4c. County of Death WASHINGTON Year) 9. Birthplace (State or Foreign Country) 1987 Maryland 10d. Inside City Limits 1 Yes 2 No 14. Race - American Indian.
Robert James Lee Burdette OCTOBE	A 21, 2004 9:49p M 4c. County of Death WASHINGTON 9. Birthplace (State or Foreign County) 1987 Maryland 10d. Inside City Limits 1X Yes 2 No 0g. Citizen of What Country? U.S.A.
## Facility Name (If not institution, give street and number) ## WASHINGTON COUNTY HOSPITAL ## HAGERSTOWN Funeral Director Director Director County Number County	4c. County of Death WASHINGTON 9. Birthplace (State or Foreign Country) 1987 Maryland 10d. Inside City Limits 1X Yes 2 No 14. Race - American Indian.
Funeral Director 5. Social Security Number 6. Sex 1 Months Days Hours Min. 120-13-2570 Usual Residence of Decedent 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 8. Date of Birthday Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 8. Date of Birthday Min. 8. Date of Birthday Min. 9. Date of Birthday Min. 9. Days Hours	9. Birthplace (State or Foreign Country) 1987 Maryland 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A.
Director 220-13-2570 1 M 2 F 17 Yrs. Months Days Hours Min. (Month, Da) Usual Residence of Decedent 17 Yrs. Months Days Hours Min. (Month, Da) Tan 22	1987 Maryland 10d. Inside City Limits 1X Yes 2 □ No 10g. Citizen of What Country? U.S.A.
.0	1 Yes 2 No 1 Yes 2 No 1 No
Maryland Washington Hagerstown 10e. Street and Number 227 East Avenue 10f. Zip Code 21740	1 Yes 2 No 1 Yes 2 No 1 No
227 East Avenue 11. Marital Status 1 X Never Married 2 Married 1 Marital Status 1 X Never Married 2 Married 1 Marital Status 1 X Never Married 2 Married 1 Marital Status 1 Marital Status 1 Marital Status 1 Marital Status 1 Married Forces? 1 Married Forces. 1 Marr	U.S.A.
11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 \(\begin{align*}	14. Race - American Indian,
	Black, White, etc. Specify: White
To be a series of the series o	16b. Kind of Business/Industry
To see the second of the secon	deides Community
17. Father's Name (First, Middle, Last) Milton Lee Burdette, SR. 18. Mother's Name (First, Middle, Last) Linda Carol Be	
The property of the polymer of the p	
Linda C. Nipper (Mother) 227 East Avenue Hayerstown M	
Linda C. Nipper (Mother) 227 East Avenue Hayerstown M. 20a. Method of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
1 Maurial 2 Cremation 3 Removal from State 1 Description 3 Remova	Poplar Springs, MD
20a. Method of Disposition A Date Date	Fiery Funeral Home stown, Maryland 21742
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Immediate Cause (Final disease or condition	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
9 0 1 S (esuiting in death) Last	
ifficate be expenditure to be expended as the burial as the burial edical Eq. (10 equention as the purial edical Eq. (2)	
TF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	acco use contribute to the cause of death?
Chronic Cocaine Use	s 2 No 3 Probably 4 Nnknown
	prior to completion of cause of
The second of th	
1 TXY'es 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Reside	
□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	winjury occurred
To be stille	eet and Number or Rural Route Number
O To the transfer of the trans	eet and Number or Rural Route Number, State) Found, 227 East Ave
Found in residence City or Town Hagersto Found in residence Found	se of a) and mannor as stated
29b. Signature and title of certifier 29c. License number 25	d. Date signed (Month, Day, Year)
Caral Hallan md OCME	OCTOBER 22, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLAD MO111 Penn Street, Baltimore, Ma	and 21201
State Registrar NOV 0 8 2004 State Registrar State Registrar Signature	TATCHE STORE

State of Maryland / Department of Health and Mental Hygien 2004 35320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** October 26, 2004 Helen Elizabeth DIVEL 1600 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Eden Pines Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mours | Min. | 8. Date of Birth
(Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 92 Yrs. 219-20-3539 Director Oct. 11,1912 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylend Department of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic avant, the Modical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Garrett Street 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: white Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) inspector clothing mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John H. Shank Esther Downey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis L. Carpenter - daughter 5 Garrett St., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/04 Hagerstown, Maryland Beaver Creek Cemetery 22. Name and Address of Facility 21. Signature of Fulferal Service Licensee MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical consinta Heart Freder かつ Examiner Due to (or as a consequence of): Physician/Medical Examiner Scherotic Carelio Vinnela To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Diractor: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, pege 2 should be detached for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) > Division of Vital Records, P.O. Box 68760. Enterille lien Alice Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Articl. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? hypothyroidis 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Detrier (Specify) ASSISTED Certification: To 1 Yes 2 -No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) していて から D18019 OCTOBER 27 2004

Registrar

Golde

MILLAT

HAGERSTOWN

MO

21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

340

32. Registrar's Signature

VASANT DATE MO

31. Dete filed (Month,

DCT 28 2004

State of Maryland / Department of Health and Mental Hygien 200 L 1 - For Stata Ragistrar 35321 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KENNETH DAY IRVIN 20, 2004 October 7:30A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4501 Ammendale Road Beltsville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∏**M 2□F Months Days Hours Min Yrs. 220-40-3657 61 Director July13, 1943 Washington, D.C Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20.4. any injury or other traumetic event, the Maryland once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Prince George's Beltsville 1 ☐ Yes 2 XNo Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 Ammendale Road 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Self employed Printing 18. Mother's Name (First, Middle, Maiden Sumame) Louise Madelin Poff Hugh Alexander Day, III Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Day -brother 11905 Gordon Avenue Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 10/21/2004 Aleandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of vier I Service Licenses Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or irjury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2**X** No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home X Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerei L 29a. Certifier 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License numbe 0 October 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Antonio B. Valentin, M.D. 7313A Hanover Parkway Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year)
OCT 2 2 2004 32. Registrar's Signature Registrar

Baltimore, Maryland 21215-0036

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hio the	Me	29h Signature and title of certifier			29c. License numb	nar	2	9d Date	signed (Month, i	Day Year)	

Exar To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funerel Director: At completely filled in by the fu

(Check only one) 29b. Signature and title of certifier

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) OCT. 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WOL If. Allan Ma 111 Penn

111 Penn Street, Baltimore, Maryland 21201

State Registrar

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygien 👂 🛭 👢 1 - For State Registrar 35324 Certificate of Death 2. Date of Death 3 Time of Death I. Decedent's Name (First, Middle, Last) Month Year **Physician** 2100 M 25 STEVEN KENNETH ESTEP 0 47 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WASHINGTON KEEDYSVILLE 2629 HAWKS HILL LANE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Yrs. Director 213-92-2760 40 14, WASHINGTON. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "naturel", or items 23s or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director KEEDYSVILLE MARYLAND WASHINGTON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21756 2629 HAWKS HILL LANE U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Black, White, etc. e filed within 72 hours after il Hygiene. other than "naturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BINDER PRINTING COMPANY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked ofth eny lipity or other freumatic event, 90x8. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hazel Wiles ROBERT ESTEP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DOROTHY WILT/Mother-in-Law 8303 MAPLEVILLE ROAD, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Denation 5 □ Other (Specify) SMITHSBURG CREMATORY 10/26/04 SMITHSBURG, MARYLAND 22. Name and Address of Facility 21. Signature of Fyn ral Service 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Palt1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) **Physician** QUUSHOT Wound /Medical Upue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: Cther: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death After t Certification: Injury 1750 1 Natural 5 Pending investigation oct 25 2004 1 ☐ Yes 2 ☑No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of thiury - At home, farm, street, factory, office building, etc. (Specify)
2627 Kawle Lake - Kest 4 Homicide Kestys Villa 21756 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Oct 26, 2004 00-1062 es and address of person who completed cause of death (Item 23a) (Type, Print) 19011 ORCHARD TERRACE ROAD, HAGERSTOWN, MD M.D Edward W. Ditto III, 31. Date filed (Month Day OCT 32. Régistrar's Signature. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#12, perINF, G839, 170, 05 TT
State of Maryland / Department of Health and Mental Hygiere 0.04

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2	Dallillore, Dermit. Pages 1 ar Department of Hear mportent: If Item any Injury or othe		21. Signature of Funeral Service Li	censee			. Name and Address					
\sim .	0 40E 8 8		Jan T.	Yelle							pring	g, MD 20904
,0			23a. Part. Enter the disease, or c shock, or heart failure. List of	omplications that c nly one cause on a	caused the death each line.	h. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	an	OXIC 6	encept	algorth	4				Onset and Death
	/Medical		resulting in death)		(or as a conseq			1				
	Examiner		Sequentially list conditions,	b								
	ם ב	Examiner	if any, leading to immediate	Due to	(or as a conseq	uence of):						
	ecute and trans	Cam	Cause (Disease or injury that initiated events resulting in death) Last	C	/01.00.0.000000							
ç	DO,		,	Due to	(or as a consequ	derice or).						
9	cate be executed physician and the burial-transit	dical		d								
C		Me	IF FEMALE:	23c If yes ou	tcome of pregna	incv.						
1001	death certifice attending of for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	ointh 2 Feta	I death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of delive nth	Day Year
SAGE C	the s	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn	nant at time of d	eatn 5	Otner (specify)					
_ 0	es that the death igned by the atter be detached for	Ph	Part II, Other significant condition	s contributing to d	eath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use cont	ribute to th	ne cause of death?
\subseteq	ires tha signed						, ,		1 🗆	Yes 2 No	3 Proba	ably 4 Unknown
7	w require	ete							24a. Was		Masa auto	an findings available
	e lav	Completed			_				auto	psy	prior to condeath?	psy findings available apletion of cause of
	VICION: The certificote rector, pag								1 ☐ Yes	2 No 1		2 □ No
三 :	OI VICAL MECORDS, F.O. Physicien: The law requires that the this certificate has been signed by the rall director, page 2 should be detached.	Be	25. Was case referred to medical examiner?	Hospital: .V.			Othe	26. Place of Dea				
0 1	Phys r this	To	1 ☐ Yes 2 🛣 No 27. Manner of Death	142		ER/Outpatien 28b. Time of	1 JL DOA	4 Ivuising n		how injury occurr		/)
	Jing Jing After fune	tlon	1 X Natural 5 ☐ Pending		of Injury oth, Day Year)	Injury	Worl	k? Yes 2 □No	204. 20001120	non mjuly occur.		
	or Attending ter death. irector: After by the fune	lica	3 Suicide 6 Could no	24 h 2	e of Injury - At ho	ome, farm, str			28f. Location	Street and Numb	er or Rura	l Route Number,
0	Jor A after Direct Dire	Certification;	4 Homicide determin	buildi	ing, etc. (Specif	y)	eet, factory, office			wn, State)		
0	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 17 Certifying	Physician: To the	e best of my kno	wledge, death	occurred at the tim	ne, date and place	, and due to the	cause(s) and ma	nner as st	ated.
5	e Hos 24 h e Fur	Medical	(Check only 2 Medical E	xaminer: On the b	asis of examina iner stated.	tion and/or in	estigation, in my or	pinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
LL.	To the within 2 To the comple	Me	29b. Signature and title of certifier	- 1	n	\mathcal{O}	29c. License	e number		29d. Date signed	1 (Month, I	Day, Year)
	2/		1 / ara	MKOG	re.	47	62	569		10/17	101	•
	12		30. Name and address of person w	no completed cau	se of death/lten	n 23a) (Type.	Print)	•			-7	
				POQUE	/ i.	ntensi	vist860	001d Geo	rgetown	Rd. Betl	nesda	, MD 20851
	St	taté	31. Date filed (Month, Day, Year)	32. F	Registrar's Signa		1 ,			· · · · · · · · · · · · · · · · · · ·		
	Regis	trar	OCT 22 2	004 0	neva	D	sparker					

State of Maryland / Department of Health and Mental Hygiens, 1 - For State Registrar 35326 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** EASTMAN RANCES 11.15 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lorien Health System Mt. Airy Carrol1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 19, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Maryland 88 214-01-7598 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Completed by Funeral Director Maryland Howard Woodbine 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2615 Florence 21797 Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Yes. Give If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental F ed bluods Murphy Margaret Donovan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 1158 Monkton Road, Monkton, MD David Eastman/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10 = 10 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Frederick Crematory 10/26/2004 Frederick, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Ligens 8 East Ridgeville Blvd., Mt. Airy, MD 21771 Approximate Interval Between Onset and Death 23a. Part I Enter the disease, o shock, or eart failure. List amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Atheroscierotic Carchiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, physicien Physician/Medical the IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No for 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ xpertens (un 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 25 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2KI No 2 his 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division Hospital or Attending After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death, I Director: Af d in by the fur 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 md manner stated. 29d, Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of certifier 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neck Rd Baltimere MD 2122 BackRiver 201-109 IARIQ MACIMOUD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 35327 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** October 2004 0935 Barbara Ann Frady /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton Union Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 5, 19 Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🗓 F Director 162-28-4152 1935 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "natural", or Items 23e or 28a-f show the Medical Examinar must be nutified at 1 ☐ Yes 2 ☑ No Elkton Director Cecil Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21921 United States 237 Old Chestnut Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ♥ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) other then Elementary/Secondary (0-12) <u>Homemaker</u> In Her Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Trapportent: If liem 27 is marked oth any jury or other treumatic event 90s8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Ann Stockman Heuber Henry William Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 237 Old Chestnut Road, Elkton, Maryland 21921 Barbara L. Nickle/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 30, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Bank Cemetery 2004 Calvert, Maryland 22, Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee maid Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** VENTRICULAR 1 minute TACHTCHROIA /Medical Due to (or as a consequence of): Examiner MYOUHEDIAL INFARCTION UNWWWW Sequentially list conditions, and localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed to has been attending physician and for use as the burial-transit SEPSIS 4 0045 Due to (or as a consequence of): Physician/Medical UKINDAY TRACT INFECTION MENOUN IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š pe 3 ☐ Probably 4 ☐ Unknown ACCUDENT 1 ☐ Yes 2 No CENEBROVASCULAR page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No EMD STAGE 2283210 24a. Was an RENAC autopsy performed? certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No his After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe it injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rulan D0058392 OCTOBER 27, 2004 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMPEEP UNION MOSPITAL 106 BOW STREET, ELKTON, MD 21921 31. Date filed (Month, Day, Year) 32, Registrar's Signature State NOV 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 35328 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year William Ernest Fleming October 1510 28 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rising Sun

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Deer Ridge Manor Cecil 8. Date of Birth (Month, Day, Year AUG 10, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 186-22-4671 76 Yrs Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural; or Items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1162 Ebenezer Church Road 21911 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1950 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1952 1 ☐ Yes 2 ☑ No Specify: \$ 3 Widowed 4 XDivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ies 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 Is markad other than "r or other traumatic evant, the Mad Graphic Arts and Elementary/Secondary (0-12) College (1-4or 5+) Offset Printing Marketing Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Ernest Flemings ဂ Ethel Harriett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Dougherty/Caregiver 1162 Ebenezer Church Road, Rising Sun, MD 21911 20b. Place of Disposition (Name of Formation, cramatory or other place)
FIORAL HILLS
Memorial Cemetery 20a Method of Disposition November 1, 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl once. Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 1 4 ☐Donation 5 ☐ Other (Specify) Tucker, Georgia 22, Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as wirdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Norm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inflinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner the attending physician and hed for use as the burial-transit certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Pres 2 □ No 3 Probably 4 Unknown Completed 24a. Was en autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funaral Diractor: After this certifice funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ASSISTED Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🖔 Other (Specify) Livin 1 ☐ Yes 2 ☐ H6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a a Funaral I 29a. Certifier 1 🖫 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29b. Signature 29d. Date signed (Monta, Day, Year) 0 J addresslof pe reon who completed cause of death (Item 23a) (Type, Print) 302 32. Registrar's Signature State NOV 0 8 2004 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	nd / Depa <i>Cel</i>	artment rtificate	of H	ealth a	and Me	ental Hyg	iene/ eg. No.	2001	+ 35	329
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Phyllis Sullivan	Galiher						2. Date of Deat Month October	Day	Yea 2004		of Death
	Examir			rive		Chevy	Cha				Mor	County of De	ry	
	Funeral Director		5. Social Security Number 6. Sex 215-48-3854	X 7. Age (In yrs. M 2□ F 91	last birthday) Yrs.	If Under	Days	If Under a	Min.	B. Date of Birth (Month, Day, Iay 21,	Year) 191		irthplece (State Country) ssachus	_
	the Maryland 28e-f show	Director	10a. State 10b. County Maryland Montgomery 10e. Street and Number		ty, Town or Lo		Code			1	On Citiz	en of What		City Limits es 2 ☐ No
	3e or	I Dir	5816 Highland Driv	re		2081					U.S.		Southly?	
980	be filed within 72 hours after death with the Maryland ital Hygiene. do other then "naturel", or Items 23e or 28e-f show event. I've Medical Examina must be notified at	by Funeral		2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decede If Yes, speci	ify Cubar	spanic Origin, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		Black, WI	nerican Indian, nite, etc. hite	
21215-0036	s within 72 ho plene. r then "natur r to Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use aker	k done d	urina most	of working	7		d of Busines Home	ss/Industry	
Maryland 2	2 should be filed withir and Mental Hygiene. Ie marked other then eumatic event, T.E.M.	To Be C	17. Father's Name (First, Middle, Last) John Leonard Sull:	lvan						First, Middle, M Carey	Aaiden S	Sumame)		
	and 2 sho salth and n 27 le m er treums		19a. Informant's Name/Relationship (Type Richard W. Galiher			-				Route Number, evy Cha	-			315
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 le marked any injury or other treumatic en once.	1	20a. Method of Disposition 1 Sparial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State St	Place of Dispo cemetary, crer Gabr	sition (Name natory or oth 1e1 S	e of her place	e) C	oct.	22,04 P			or Town, State aryland	l
Balt	permit. Departi Import any inj		21. Signature of Tunera/Service License		5	Name and oseph	isco	nsin	Ave 1	V.W. Wa	shir	gton.	D.C. 2	20016
	Physician		23a. Part Enter the disease, or complices that cause (Final disease or condition resulting in death)	Sepsis		er the mode	of dying	, such as	cardiac or	respiratory arre	est,		Approxim Interval B Onset an	etween
	/Medical Examiner	Ļ		Due to (or as a consect Alzheim Due to (or as a consect Due to (or as a consec	ner's D	iseas	е							-
8760, I	sate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consec										
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	ic. If yes, outcome of pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3□	Ectopic pre					23	3d. Date of d Month	elivery Day	Year
rds, P.	quires that n signed t uld be det	by	Part II. Other significant conditions con Anemia ; Chronic G	ributing to death but not res astrointestor	sulting in the unal BIo	nderlying ca	use give SS	n in Part I.		23e. Did tob	_		to the cause of	f death?]Unknown
l Records,		Completed	Unknown Etiology						_	24a. Was ar autops perform 1 Yes 2	v	24b. Were prior to death?	autopsy finding completion of es 2 No	s available cause of
Vital	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	ospital:			0.45		of Death (Check only one	X		X	
of	4 = E IE	lon; To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury Work	at Nu		e Sd. O hibe ho		Other (Sp	pecify)	
Division	of or Attendia after death. Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)		_			f. Location (Str City or Town	reet and , State)	Number or i	Rural Route Nu	ımber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Medical C		ician: To the best of my knoer: On the basis of examination and manner stated.										9(s)
)	To the within to the comp	Ž	29b. Signature and little of certifier		_~0		License				0-19		nth, Day, Year)	
		8	30. Name and address of person who co								1 00	016		
	Sta	ate	Susan J. Miller, M 31. Date filed (Month, Day, Year)	32. Registrar's Signa			ce,		sda,	laryLan	a 20	ΙΩΙΌ		

			State of Marylar				ental Hygier	2006	35330
			1 - Stete Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of L		Reg. I	No.	3. Time of Death
ı	Physici		Sacie	Cail	1000	ص		Day Year	1 10 '30 M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	CHIPCHES	4c. County of Deat	1
ı			The Johns Hoplins Hosp	DitaL	Bak	timone	City	None	
	Funeral		5. Social Security Number 6. Social Security Number 7. Age (In frs.	. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 2,	9. Birth	nplace (State or Foreign
	Director		060-22-6831 76 Usual Residence of Decedent	TIS.			Sept. 2,	1928 Per	nsylvania
	yland yland			ity, Town or Loc	ation				10d. Inside City Limits
	e Mar	ctor	Maryland Montgomery	Kensing	gton				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zîp Code		10g.	Citizen of What Co	untry?
	eath v	eral	3317 Ferndale Street 11. Marital Status 12. Was Decedent Ever in U	10 112 14	20895			ited Stat	
930	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show offical Experiment has be mailled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U 4 mmed Forces? 1 XYes 2 No If Yes, Give 7 Year or Dates: WWI	lf 1	vas Decedent of HI Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ciry Yes or No- lican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	S 23	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa kind of work done d O NOT use retired,	uring most of workin.	g 16b.	Kind of Business/I	ndustry
212		Com	Elementary/Secondary (0-12) College (1-4or 5+)	Accou	ıntant		F	inancial	
	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		en Sumame)	
yla		J.	Ray Gillespie			Margare			
Maryland	S 5 5 5		Jack A. Gillespie, II / Son		g Address <i>(Street a</i> Ontour Ro	nd Number or Rural			
	os 1 and 2 of Health item 27		20a. Method of Disposition 20b. F		ition (Name of atory or other place		Airy, Mar	y Land 217 Location - City or 3	
Ë	Pages nent of I int: If it		- La condition of Literature o	_	National		,2004 Ar1	ington, V	irginia
Baltimore,	permit, Page Depertment of Important: If any injury or ance.		21. Sign, fure of Funeral Service Licensee	22.	Name and Addres	s of Facility Star	uffer Fun	eral Home	s, P.A.
			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.			ille Blvd		ry, Maryl	Approximate
	Physician		Immediate Cause (Final						Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Tatal Due to (or as a consequence)		thmia		· · · · · · · · · · · · · · · · · · ·	,	minutes
ŧ.	Examiner		Sequentially list conditions. b. Is chemi	·c (andio	myoma	thy		o Days
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	7 1	myoma			
	icate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last c. My DC OUC	quence of):	INE	exction	4		& Days
58760,	e be e	dical	d						
_		a ·							
P.O. Box	that the death certific led by the attending p detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of descriptions of the pregnant at time of descriptions of the pregnant at time of descriptions of the pregnant at time of descriptions of the pregnant at time of descriptions of the pregnant at time of descriptions of the pregnant at time of descriptions of the pregnant at time of descriptions of the pregnant at time of descriptions of the past 12 ☐ Live birth 2 ☐ Feta descriptions of the past 12 ☐ Live birth 2 ☐	aldeath 3□E	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	rery Day Year
	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not res	sulting in the unc	derlying cause give	n in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ıdş	w require been sig should b						1 ☐ Yes	2□No 3□Pro	bably 4 Dunknown
Il Records,	The ate ha	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
Vital	Physiclan: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		Otho	26. Place of Death (
of	Phys rthis ral dii	1. To	1 ☐ Yes 2 No Pospital: ValInpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of		4 - Nursing Home	e 5 Residence		fy)
lon	ding h. Afte fune	tlon	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	tnjury	28c. injury Work' M 1 □ Y	es 2 □No	10. Describe (1014 III)	ury occurred	
Division	Dir	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of tnjury - At h building, etc. (Specification of the country of the count	ome, farm, stree fy)	et, factory, office	28	f. Location (Street and City or Town, Sta		al Route Number,
ш	Hospital 24 hours a Funeral I tely filled	cal Ce	29a. Certifier Certifying Physician: To the best of my kno Check only Medical Examiner: On the basis of examina	owledge, death	occurred at the time	e, date and place, an	d due to the cause(s) and manner as s	stated.
	To the H within 24 To the Fi complete	Medical	one) and manner stated.	MOIT ATTO/OF INVE					
	wit To	-	29b. Signature and title of continue		29c. License			ate signed (Month,	•
•			30. Name and address of person who completed cause of death (Item			-000	OCTO	BER 22,	2004
	24		BRIAN BAKER JOHNS HOPKINS HOSPITA	AL 600	NERTH WO	FE STREET	BALTIMO	E MARYLA	ND 21287
1	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 6 2004			uls			

			For State Ragistrar	State	of Maryl		artment of H		Mental Hyg	giene 20) 4	35331
			Decedent's Name (First, Middle	, Last)					2. Date of Dea	ith		3. Time of Death
	Physicia		Joa	nn Gibso	n				Month October	Day 26 20	Year 004	1140 A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City, Town, or	Location of Death		4c. County		1140 2
-0.			87 Hilltop Roa	nd			Elkton			Cec	:i1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1	9. Birthp	place (State or Foreign
Tặt.	Director		232-50-4783	1 ☐ M 2 🂢 F	69	Yrs.	World's Days	Tiours Willi.	April 10	, 1935	Cow West	t Virginia
	pu s		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town or Lo	ocation					10d. Inside City Limits
	faryia sho	ក		1	1.00	Elkton						1 ☐ Yes 2 ☑ No
	28a-i	Director	Maryland Ceci	<u> </u>		EIKLOII	10f. Zip Code			log. Citizen of V	Mhat Cour	
	with se or			٦.			21921		'		_	•
	leath	era	87 Hilltop Roa	12. Was Dec	edent Ever	in U.S. 13. 1	Was Decedent of Hi	spanic Origin? (Si	pecify Yes or No-	Unite		ates can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, I'm Medical Examinating 1, ust be routilled at once.	by Funeral	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed F ed 1 Tes If Yes, G Year or I	2⊠No ive	1	If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	n, Mexican, Puèrt Specify:	o Rican, etc.)		ck, White,	etc.
ĕ	2 hou	ted	15. Decedent	's Education		16a. Dece	dent's Usual Occupa	ition		16b. Kind of Bu		
2	hin 7:	Completed	(Specify only highes Elementary/Secondary (0-12)) (1-4or 5+)	(Give	kind of work done of DO NOT use retired,	luring most of wor.)	king			
2	od wit	Con	9			Hor	nemaker			In Her	Own	Home
g	tal Hydry	Be (17. Father's Name (First, Middle, L	_ast)				18. Mother's Nam	ne (First, Middle, i	Maiden Sumam	ne)	
₹	ould Men marke marke	ဥ	William Lovejo					Anne Se				
Maryland 21215-0036	12 sh h and 7 Is m		19a. Informant's Name/Relationsh				ng Address (Street a					Code)
	1 and Healti em 2 ther 1		Duane A. Gibso	n/Son	20	b. Place of Dispo	Hilltop Ro	oad, Elki		yland 2 20c. Location -		ouro Ctato
Baltimore,	Pages nent of H ant: If its ary or of		1 Burial 2 ☐ Cremation		State	cemetery, crer	natory or other place	INOVCI	mber 1,	Hurric	ane,	
별	nit. Partme ortani injury		' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		1 0		iew Cemete			West V	irgir	nia
Ba	permi Depa Impo any i		Donald S	3.4.	Α.,	H:	Name and Addresticks Home 3 W. Sto	for Fund	erals, P	.A.	~ .er - 1 -	201021
*			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the c						aryıc	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			= 1.1/310	· e-K					Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a con	- LUNC sequence of):						
	Examiner		Sequentially list conditions,	b. CA2	con	- COLO	N					
-/	רֹים ≕	Iner	if any, leading to immediate Cause (Disease or injury			sequence of):						
d.	ecute and -trans	Examiner	that initiated events resulting in death) Last	c. Oh.	CAR	sequence of):	NEYS					
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687		edical		d	DIC		1.43011					
P.O. Box	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		birth 2□F nant at time	etal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delive	ery Day Year
	res that iigned b be deta	by PI	Part II. Other significant condition	ns contributing to	death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did tob			ne cause of death?
ord	w require been si should t								1 □ Y€	es 2□No	3 ☑ Prob	ably 4 Unknown
Division of Vital Records,	The law r te has be age 2 sh	Completed							24a. Was a autops perform	ned2	rior to cor leath?	psy findings available inpletion of cause of
ta		BeC	25. Was case referred to medical					26. Place of Deal	1 ☐ Yes 2 th (Check only on		Yes	2)2 140
<u></u>	nysic nis ce I direc	70 1	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient	2 ER/Outpatien	t 3□ DOA Othe	r: 4 🗆 Nursing Ho	ome 5 Reside	ence 6 Othe	er (Specify	1)
0	Attending Physician: r death. ector: Atter this certificaby the funeral director.		27. Manper of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Yea	28b. Time of Injury	Work	?	28d. Describe ho	w injury occurr	ed	
Sio	tendi leath. tor: A the fu	catl	2 Accident investig 3 Suicide 6 Could n	ation				'es 2□No				_
Ω	Hospital or Attend 14 hours after deatl Funeral Director: tely filled in by the	Certification:	4 Homicide determi	200. Plac	e of injury - F ling, etc. (Sp	At home, farm, streecify)	eet, factory, office		28f. Location (St. City or Town	reet and Numbe n. State)	er or Hura	I Houte Number,
	To the Hospital or Attenwithin 24 hours after dealing the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Cartifying (Check only one) 2 Madical E	xaminar: On the l	e best of my basis of exam ner stated.	knowledge, death nination and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, da	ause(s) and mai ate and place, a	nner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number	25	9d. Date signed	(Month,	Day, Year)
			Julintoli	ani	6.		000-	7463		10/2	7/0	φ
			30. Name and address of person v				•					
	10		Rolando A. Najer	ra, M.D.,	138 (Reğistrer's Si	Cathedra	l Street,	Elkton,	Marylan	d 21921		
	Sta Registr		NOV 0 8		Denier S	-	from the					
				/		/ -	Lake a state of					

State of Maryland / Department of Health and Mental Hygien 2004 35332 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 19:50 PM 10 Mary Lou Galliher 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SACRED HOSPITAL ALLEGANY HEART 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 KF 64 Yrs. Director 220-36-8728 Oct. 4,1940 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director W Hampshire Three Churches 10e. Street and Number 10g. Citizen of What Country? HC-64 Box 2090 26757 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leon Smigal Helen Grobowski 19a. Informant's Name/Relationship (Type, Print (husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McClellan T. Galliher 20b. Place of Disposition (Name of cemetery, crematory or other place)

Branch Mt. Baptist Three Churches, W 26757
Date 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/3/04 Three Churches, W 4 ☐ Donation 5 ☐ Other (Specify) Cemetery
22. Name and Address of Facility
22. Name and Address of Facility
McKee Funeral Home Inc. of Funeral Service License P.O. Box 270 Augusta, WV 26704 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician AVENOCARCINOMA LIVER 6 MOS. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sicien and burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 12 No 1 ☐ Yes of or Attending Physicien: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier D-14865 Moleustiano Janh 30. Name and address of person who impleted cause of death (Item 3a) (Tipe, Print) BARNERA MEMORAL AVE., CUMBERLAND JR. LOBUSTIANO 31. Date filed (Month, Day, Year) 32. Togistrar's Signature State NOV 0 8 2004 Registrar

DHMH 17 Rev 1/2001

			For State Registrer	State of Mar		artment rtificate			ınd M		jiene	001	÷	35333
	Physici		1. Decedent's Name (First, Middle, Last) Imogene Elaine Jon	es						2. Date of Dea Month	Day	Ye		3. Time of Death A
	/Medic Examir		4a. Facility Name (If not institution, give s Washington County	treet and number)		4b. City, Hager		Location of	f Death	October	4c.	200 County of C shing	eath	0020
	Funeral Director		5. Social Security Number 6. Sex 217-28-5409		In yrs. last birthday) 72 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Oay) 03/19/1	, Year)	9.	Birthpi Coun	lace (State or Foreign try) MD
	Maryland a-f show	tor	10a. State 10b. County MD Washingto		Oc. City, Town or Lo Hagerstov								10	0d. Inside City Limits 1 Yes 2 No
	th with the 23e or 28	al Director	10e. Street and Number 478 Pangborn Blvd.	, Apt. 3		10f. Zip 21	Code L742			1	0g. Citiz	en of What	Coun	try?
900	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "netural", or Itams 23e or 28e-f show event, the Mcdical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Was Decedent Eve Armed Forces? □ Yes 2 No If Yes, Give Year or Dates:	'	Was Decedif Yes, spec	rfy Cubar	spanic Orig n, Mexican, Specity:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		4. Race - A Black, W Specify:	/hite, e	
Baltimore, Maryland 21215-0036	e filed within 72 h at Hygiene. other then "netu vant, II e Mod cal	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	life. L	tent's Usual kind of won DO NOT use Care	k done di e retired)	uring most		ng		d of Busine		rnment
yland	2 should be fill and Mental Hy Ia marked oth reumetic evant	To Be	17. Father's Name (First, Middle, Last) Gilbert Raymond Su					Sall:	ie L	(First, Middle, Moven Joi	nes			
, Mar	D = L =		19a. Informant's Name/Relationship (Type Harry G. Jones, Sr.							Route Number,				Code)
more,	permit. Pages 1 an Department of Heall Importent: If itam 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	1	20b. Place of Dispo cemetery, cren Salem Red	natory`or oti	her place	n. No		ate . 2004 I		ation - City		
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service License	2				of Facility	Gera		Minn	ich F	une	ral Home
8760,	cate be executed /Medical Examiner the pural-transit the pural-transit	al Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiad events resulting in death) Last	Due to (or as a c	consequence of):	er the mode	e of dying lena ltu	9 9	ardiac or		est,			Approximate Interval Batween Onset and Death
.O. Box 687	The law requires that the death certificate ate has been signed by the attending phy: oage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of p 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pre					23	d. Date of o		y Day Year
Ω.	w requires that been signed by should be deta	þ	Part II. Other significant conditions cont	ributing to death but n	not resulting in the un	derlying ca	use giver	n in Part I.			acco us		to the	cause of death?
Vital Records,		Completed								24a. Was an autopsy perform	/	24b. Were prior t death 1 \(\sum Y\)	o com	sy findings available pletion of cause of
Division of Vita	iding Phyaician: Th th. : After this certificate funeral director, pag	ToB	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury		Other c. Injury a Work?	4 ☐ Nurs	sing Hom	Check onl one e 5 Resider 3d. Describe hor	nce 6		pecify)	
Divis	al or Attar s after dea I Diractor d in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	- At home, farm, stre Specify)	eet, factory,	office		28	Bf. Location (Str. City or Town,	eet and State)	Number or	Rural	Route Number,
	To the Hospital or Attanding I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	edical (29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of m er: On the basis of ex and manner stated	amination and/or inv	occurred at estigation, i	t the time in my opin	, date and nion, death	place, ar	nd due to the car d at the time, da	use(s) a te and p	nd manner lace, and d	as stai	ed. he cause(s)
)	To th To th comp		29b. Signature and title of certifier	ulel		29c.	License	number	G1	29	d. Date	signed (Mo	nth. D	ay, Year)
+	H-d		30. Name and address of person who con	pleted cause of death	h (Item 23a) (Type, F	Print)	11 t	003	716 Hm	41-1	70	1716	· · ·	7
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	h (Item 23a) (Type, F 26 OPOL Signature	eshi	un		1109	. Jud.	C	17		

State of Maryland / Department of Health and Mental Hygier 10 35334 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 26 Joann Curry Johnson 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 47 219-74-4144 Director 1957 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Evaniner must be notified at 1 Yes 2 □ No Washington Hagerstown Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21742 1314 Potomac Ave. Apt. 5 U.S.A. filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 XNo Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Counselor Prision Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avant once. Be Frieda Marie Seaton Jack Eugene Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9433 Crystal Falls Drive Hagerstown Maryland 21740 Jeannie Graybill (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Smithsburg Crematory Oct.28, 04 Smithsburg Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 21. Signature Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hour /Medical Due to (or as a consequence of): sancytopene Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2∏ No 1 🗌 Yes 2 No 1 Yes To the Hospital or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗷 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of centiler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2821 32. Registrar's Signature

State

Registrar

OCT 28 2004

			For Stete Registrar	State of Ma	iryland / Depa <i>Ce</i>	artment of I <i>rtificate of</i>	Health and N Death	Mental Hyg Re	ien 2 004	35335
	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Death	19, 2004°	3. Time of Death
	/Medic Examin	cal	Soon E. Kim 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	9:05 P M
¥			Casey House			Rockvi			Montgo	
	Funeral Director			X 7. Age	(In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Feb. 5,	^Y 2 ^a 2, 1917 Ko	thplace (State or Foreign buntry) **Tea
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary 1-f she	tor	Maryland Montgomer	у	Gaithersb	urg				1 Yes 2 No
	ith tha	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	ountry?
	s 23e		17060 King James W			20877			USA	
0000	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant, tra Madical Ever if armust be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2√ N If Yes, Give Year or Dates:	0	Was Decedent of P If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
20-0	'2 hou		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation	. 1	16b. Kind of Business	
7	within 7 ene. than "n re Med	Completed	(Specify only highest grad	College (1-4or 5-	+) life.	hanic	during most of work d)		Train Comp	anv
ana	e filed al Hygi othar vant, l	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
yıaı	ould b Menta karkad	To	Back Joon Kim				Unknown			
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Ty Yung Ja Kim- Daugh					,	City or Town, State, 2	Zip Code)
กั	f Heali		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Silver Spi		20904 20c. Location - City or	Town, State
Ē	Page:		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Ft. Linc	matory or other pla oln Crema	atory 10/2	22/04 H	Brentwood,	MD
pallimore	parmit. Departr Importe any inju		21. Signature of Funeral Service Licens	17.11 >					ldi Funera	1 Home ng, MD 20904
i	·		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each line	the death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician	V.	Immediate Cause (Final disease or condition resulting in death)	Suba	unal	hemat				Onset and Death
	/Medical Examiner		ſ	Due to (or as a	consequence of):					
	p ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
,00700	icate be executed physician and s the burial-transit			1	00/130406/100 01/.					
0	rtificati ng phy as the	Medical	IF FEMALE:							
O. DOX	The law requires that the death certificate be executed ate has been signad by the attending physician and page 2 should ba detached for usa as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal death 3□	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	very Day Year
ŗ	that the	y Ph	Part II. Dther significant conditions con	ntributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
cords,	equires en sign	ed by	Dementia					1 ☐ Yes	s 2 0 No 3 □ Pro	obably 4 Unknown
ני	law re las be	Completed						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
[]	ician: The lav certificate has rector, page 2			-				perform 1 Yes 2	No 1 ☐ Yes	212/16
>	Physician: r this certifica ral director, i	o Be	25. Was case referred to medical examiner? 1 ⊠ Yes 2 □ No	lospital:	nt 2 ER/Outpatien	at 3 DOA Oth		h <i>(Check only one</i> me 5□ Resider	/	ey House
	ng Phy Iter thi neral o	n; T	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	28b. Time of			28d. Describe how		11
2	tendii Jeath. tor: Ai the fu	catio	2 Accident investigation 3 Suicide 6 Could not be	unknou	in unknow	Vh M 1 🗆	Yes 2 No	multi	ple ta	<i>lls</i>
2	after after of In Dirac	Certification;	4 Homicide determined	building etc.		eet, factory, office		City or Town,	bet and Number or Ru State) NOWH	ral Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the *cueral Diractor: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier Check only one) Check only	sicien: To the best of	f my knowledge, death examination and/or inv	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occurr	and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	0 621	an hung	29c. Licens	e number	290	d. Date signed (Month	n, Day, Year)
	3		Patricia lon	sko M	y) mix		51916	0	Oct. 19	2004
			30. Name and address of person who co	Ko Nay,	11/19 Roc	KVI/le	Pike, G	-100, K	ockville,	MD 20852
	Sta Registra		31. Date filed (Month, Day, Year) OCT 22 200	32. Fegistra	r's Signature	Sparks	/		,	

State of Maryland / Department of Health and Mental Hygien 0 0 4 35336 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 2004 4:35 P Evelvn Keller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Vindobona Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🕏 F Days Hours 213-18-9305 88 Yrs Director March 19,1916 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits s 23a or 28e-f show 1X Yes 2 □ No Maryland Frederick Brunswick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 313 West B Street 21716 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status freumatic event, the Mudical Examiner: permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Inportent: If item 27 is marked other than "natural", or iten any injury or other treumatic event, the Modical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Nora Whitehair Clarence Mullendore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Tritapoe Dr., Knoxville, MD 21758 Georgie Hoffmaster/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 10/26/2004 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee; 23a. Part. Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dyneart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 1100 North Maple Ave., Brunswick, MD 21716 Approximate Interval Between Onset and Death Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 DANO 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physicien: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funerel Dire the Hospitet 1 🔀 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 100 MD0020890 26 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 and Sucres Gessect smisso (010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	iryland /		artmen <i>rtificate</i>			nd Me		iene	'nμ	35337
	Physic		Decedent's Name (First, Middle, Last) Irene		s						2. Date of Deat Month Novembe		004°	3. Time of Death 8:20 AM M
1	/Medi Examir		4a. Facility Name (If not institution, give 5223 Muirfield	street and number)					Location of ille	Death		4c. Count		
-	Funeral Director		5. Social Security Number 6. Security Number 91-07-0109	7. Age	(In yrs. last b	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. J	Date of Birth (Month, Bay, an. 0,	⁷ 1916		lace (State or Foreign Trusetts
	e Maryland Sa-f show tiffed at	ctor	10a. State 10b. County Maryland Frederic	ck	10c. City, To Ijams			-					1	0d. Inside City Limits
	23a or 21	ai Dire	10e. Street and Number 5223 Muirfield	Drive			10f. Zip	Code 217.	54		10	Og. Citizen of U.S.A		ntry?
9036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show styling or other traumatic event, the M. dical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married XXWidowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes ②XXN If Yes, Give Year or Dates:	ver in U.S.		Vas Deced f Yes, spec		spanic Origin, Mexican, Specify:	in? (Specit Puerto Ric	fy Yes or No- can, etc.)	Bla	ce - Americ ck, White, y: Whi	etc.
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	and 2 sho saith and n 27 is mu	i	19a. Informant's Name/Relationship (Ty Peter Katsotis, se		19	9b. Mailin 5223	g Address Muir	(Street a	nd Number d Dr.	or Rural R , Ija	Route Number, IMSV i lle	City or Town,	State, Zip 2 17 54	Code)
Baltimore,	Pages 1 anneut of He ant: If Item ury or othe	3	20a Method of Disposition ABurial 2 Cremation 3 P 4 Donation 5 Other (Specify)	emoval from State	Van I	ery, crem	atory or ot	her place	Nov	v. 5,		North		wn, State Swick, NJ
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service License	100	100255	Ke 10	Name and eeney 06 Eas	and st Cl	of Facility Basfo nurch	ord P	A Funei Freder	cal Hon	ne 10 21	701
	Inysician Independent Independ	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	e of):	color	/	A					Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal deat		Ectopic pre Other (spe					23d. Dat Mo	e of delive	ry Day Year
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=	tel or Attendi s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, fa (Specify)	arm, stre	et, factory,	office		28f.	Location (Stre City or Town,	et and Numbe State)	er or Rural	Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	Medical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	xamination ar	e, death nd/or inve	occurred at estigation, i	the time	, date and p nion, death	place, and occurred a	due to the cau at the time, date	se(s) and ma e and place, a	nner as sta and due to	ted. the cause(s)
)	To the To the Complet	×	29b. Signature and title of certifier/					License i				d. Date signed ovembe		
	5		30. Name and addr s of pers n who con KimAhn 1. Le, N					.ke,	Frede	rick	, Marvl	and 21	702	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 20	32. Registrar		8	4	OLE	-		, ,			

		For . State Registrar	State of Maryland		rtment of H tificate of L				04	35338
Physicia		1. Decedent's Name (First, Middle, Last) Helen I	Kahle				2. Date of Dea Month 10	Day	Year 04	3. Time of Death 2:30 AM
/Medic Examin		4a. Fecility Name (If not institution, give st 5711 Park Drive	reet and number)		4b. City, Town, or Bowie	Location of Death	1	4c. County		orge's
Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02/17/	Year)	9. Birthp	place (State or Foreign
Q		Usuel Residence of Decedent 10a, State 10b. County		Town or Loc	cation		02/1//	1714		Od. Inside City Limits
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eath with		5711 Park Drive	2. Was Decedent Ever in U.S	13. V	20715	ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race	- Americ	can Indian,
JSO irs after d	by Funeral	1 Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	If	Yes, specify Cuba ☐ Yes 2 No	n, Mexican, Puerto Specify:	Rican, etc.)	Blac	k, White, · Whi	etc.
ING 21213-UU30 be filed within 72 hours after death with the Marylan ital Hygiene. d other than "naturel", or items 23e or 28e-f show event, the Medical Extrainer must be notified at	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give)	ent's Usual Occupa and of work done of O NOT use retired	turing most of work	ing	16b. Kind of Bu		dustry
d be filed we sental Hygier to cevent, Ill.	Be Coi	17. Father's Name (First, Middle, Last)	2	Nuise		18. Mother's Nam	e (First, Middle,	U.S.Na Maiden Sumam		
	2	Walter McDonald Kahi 19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a	Ouida M	abel Hun		State, Zip	Code)
0 2 5 0		Mary Frances Lemat 20a. Method of Disposition		-	Western	Ave. NW,	Washing	gton, DC		015 own, State
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	Cei	metery, crem	atory or other plac	atory _{10/2}	9/2004	Alexano		
Danit. Departit. Departimport		21. Signature of Fundral Service Prensed	2/2002		Name and Address lvent Fun nnapolis	ss of Facility Leral and MD and F	Cremati alls Chu	on Serv	ices	
Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death.	Do not ente	/	g, such as cardiac		est,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):		., (),				
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death certific	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mor		ery Day Year
		Part II. Other significant conditions cont	ributing to death but not resul	ting in the un	derlying cause give	en in Part I.	23e. Did to	. /		ne cause of death?
The law The law ate has b	Completed						24a. Was a autop: perfor 1 Yes	med? d	Vere auto rior to co eath?	psy findings available mpletion of cause of
VITC sician cartifia rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 XVio	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	3□ DOA Othe	26. Place of Deat	h (Check only or		er (Specif	v)
	tlon: T	27. Manner of Death 1 Statural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injun Work	at	28d. Describe h			,,
i Diffig	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Town	treet and Numbe n, State)	er or Rura	al Route Number,
To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical (29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	cian: To the best of my know er: On the basis of examinational manner stated.	rledge, death on and/or inv	occurred at the time estigation, in my of	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and mai late and place, a	nner as s	tated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	M		29c. License	number	2	29d. Date signed	(Month.	Day, Year)
n		30. Name and address of person who cor	npleted cause of death (Item)	- 1	Print)	A	- 1	01	3/./	~ O
Sta Registr	-	31. Date filed (Month, Day, Year) NOV 0 8 200	32. Registrar's Signatu		1000	2 / 1/	Idik	200	17	,,,,

DHMH 17 Rev 1/2001

		1 - State Registrar 1. Decedent's Name (First, Middle, Last	State of M	aryland.		artment tificate				R Date of Dea	eg. N2 (004	3533
Physici /Medic Examin	cal	4a. Fecility Name (If not institution, give	street and number)	nond M			Town, or	Location of			Day 22, 20 4c. Co	Year 004 unty of Death	1820
Funeral Director		5. Social Security Number 6. Se 228-24-2286	Regional Medi x 7. Ag M 2 🗆 F	ical Cente ge (In yrs. last 76		If Under Months	1 Year Days	If Under 24	Alisbui Hrs. 8 Min. 8	y Date of Birth (Month, Day Dec 25,	Year) 1927		nico place (State or Fore Intry) /irginia
ne Maryland 8a-f show utilies at	ector	Usual Residence of Decedent 10a. State VA Accon	nack	10c. City, T	1	eague							10d. Inside City Limi
sath with t s 23a or 2 uust be n	Funeral Director	10e. Street and Number 5410 Main Street	10 W D		10	10f. Zip		23336				of What Cou	١.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other trsumatic event, the Medical Examinar must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	No		1□Yes 2	2 🖄 No	Specify:	Puerto Rid	y Yes or No- can, etc.)	Spi		vhite
ad within 72 i /giene. ar than "nat i, the Nedice	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			(Give	OO NOT us	k done d e retired)	urina most o				of Business/Ir	ce Center
ould be fill I Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last) Edward									Reyno	olds	
and 2 shealth and n 27 is m		19a. Informant's Name/Relationship (T) Deborah Turner Daughte			P.C). Box 6	34 Ch	incoteag		Route Number	City or To	wn, State, Zij	o Code)
Pages 1 Iment of H Iant: If Iter jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place ceme	etery, cren	sition (Nam natory or ot anics Ce	her place		Dat 10/	27/04		on - City or T nincoteag	
Departition Depart		21. Signature of Funeral Service Licens Amanda C-			22	. Name and Saly 632	ver Fu	neral Ho	me et Chir	coteague	. Virgini	ia 23336	
death certificate be executed Wedical e attending physicien and of for use as the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as Due to (or as	D a consequent	ce of):	Fou	lu	<u>ب</u>					Interval Between Onset and Death Onset and Onset and Onset and Onset on Ons
death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pre						Date of delive	ery Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death b	ut not resultin	g in the ur	iderlying ca	use give	n in Part I.			acco use o		he cause of death? pably 4 □Unknov
The lar	Completed								_	24a. Was an autops perform	y ned?	prior to co death?	opsy findings availab impletion of cause o
Attending Physician: The death. Fer death. Fector: After this certificate by the funeral director. pag	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	lospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 281	Outpatien b. Time of Injury		Other Sc. Injury Work	° 4 🗍 Nursi	ng Home 28d	5 Reside	nce 6 🗆		<i>y</i>)
	Certification:	3 🗍 Suicide 6 🗍 Could not be 4 🗍 Homicide determined	28e. Place of Inj building, et	ury - At home, c. (Specify)	, farm, stre	eet, factory,	office		28f	Location (St. City or Town	reet and Nu , State)	mber or Rura	al Route Number,
To the Hospital or within 24 hours afte to the Funaral Discompletely filled in	edicai	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner sta	f examination	dge, death and/or inv	occurred a estigation,	t the time in my opi	e, date and p nion, death	olace, and occurred	due to the ca at the time, da	use(s) and ite and plac	manner as s ce, and due to	tated. the cause(s)
To the within 2 To the Complet	M	29b. Signature and title of certifier 30. Name and ad ress of person who co	omplied cause of d	eath (Item 23	a) (Type, 1	0	License	number J (4 3	561			gned (Month,	
Sta Registr	_	Dr. Donald Amrien Willow 31. Date filed (Month, Day, Year) 0CT 2 7 20	Street Chino		A. 2333								

DHMH 17 Rev 1/2001

		4	For Stata Registrar	State	of Maryla	•	artment of H rtificate of I		-	giene Rag. No. 0 0 L	35340
	Dhusisi		1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	Day Y	3. Time of Death
	Physicia /Medic	al	LINDA LEE MYEI				45 City Taylor	I anation of Door	061	28 20 6 4c. County of	
	Examin	er	4a. Facility Name (If not institution 3428 HARPERS FI				4b. City, Town, or S.	HARPSBUR			JASHINGTON
	Funeral		5. Social Security Number 218-502627	6. Sex 1 □ M 21公 F	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th y, Year 044	Birthplace (State or Foreign County) MARYLAND
	Director	}	Usual Residence of Decedent			113.			0011	,	PIAKLIJAND
	yland how		10a. State 10b. County		10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Be-f s	Director		ASHINGTON	I			RPSBURG		10g. Citizen of Wha	1 □Yes 2 ☑ No
	with the e or 2	Dire	10e. Street and Number 3428 HARPERS FI	ERRY ROAT)		10f. Zip Code	1782		rog. Citizen of wha	U.S.A.
	death	Funeral	11. Marital Status	12. Was De	cedent Ever in	1 U.S. 13.	Was Decedent of H	ispanic Origin? (5	Specify Yes or No		American Indian, White, etc.
36	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other then "natural", or Items 23e or 28e-f show artic event, the Medical Examiner wast be motified at	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 Tyes If Yes, 0 Year or	2 MNo Sive		1 ☐ Yes 2 🎇 No	Specify:	to riican, etc.,	Specify:	WHITE
Ş	thour atural cal Ex		15. Deceden	t's Education			dent's Usual Occup		adala a	16b. Kind of Busin	
212	thin 72 en "na	Completed	(Specify only higher Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	kind of work done of DO NOT use retired	1)) W ID G = 3	IG HOME
2	led wil		12 17. Father's Name (First, Middle,	(ant)			NURSIN	G ASSIST		NURSII , Maiden Sumame)	NG HOME
and	d be fi	o Be	ROY ASBURY BUS						CAROLINE		
Maryland 21215-0036	g e E E	ဋ	19a. Informant's Name/Relations PATRICK E. MYE	hip (Type, Print)						er, City or Town, Sta 1807 HAG	ite, Zip Code) ERSTOWN, MD
altimore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State		osition (Name of matory or other plac MANOR CEM	(e) 11/(Date 01/2004	20c. Location - Cit	y or Town, State
Baltin	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre-		21. Signature of Funeral Surice	Licensee	eul M.	2	2. Name and Addre	ss of Facility	7606	OLD NATION	NAL PIKE
			23a. Part1. Enter the disease, or shock, or heart failure. List								Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition	, 9	1		Y Ezu	0.00			Onset and Death
ı	/Medical Examiner		resulting in death)	Due t	o (or as a con	sequence of):	1				
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due t	o (or as a cons	sequence of):					
	cuted id ansit	Examiner	that initiated events	S .							
8760,	cate be executed obysician and the burial-transit	al Exa	resulting in death) Last	Due t	o (or as a con:	sequence of):					
687	physics the t	edical		d							
.O. Box (The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	outcome of pre birth 2 F gnant at time known	etal death 3	⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>	1		23d. Date of Month	of delivery Day Year
<u>α</u>	uires that I signed by Id be deta	d by Pr	Part II. Other significant conditi	ons contributing to	death but not	resulting in the t	underlying cause giv	en in Part I.			ute to the cause of death? Probably 4 Unknown
Division of Vital Records,	he taw require te has been sii age 2 should t	Completed								psy pric ormed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \(\subseteq \text{No} \)
ita	ien: '	BeC	25. Was case referred to medica examiner?						ath (Check only		
<u>></u>	Physicien: r this certific ral director,	ဥ	1.☐Yes 2☐No	-		2 ER/Outpatie	-	4 Nursing		idence 6 Other	(Specify)
ono	Attending F r death. sctor: After by the funer	tlon:	27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	(4.4	te of Injury o <i>nth, Day</i> Yea		Wor	k? Yes 2∐No	200. 20001120	now injury coodings	
Divisi	or Atten after dea Director	Certification;	3 Suicide 6 Could 4 Homicide deterr	nined 286. Pla	ice of Injury - A		treet, factory, office			(Street and Number wn, State)	or Rural Route Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifyi (Check only one) 1 Medical	Examiner: On the	the best of my basis of exam anner stated.	knowledge, dea nination and/or i	th occurred at the time the ti	me, date and place	e, and due to the curred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To the To the comple	Me	29b. Signature and title of certific	J. D.7	LO ET	175	29c. Licens	e number - 1062		29d. Date signed (
1	X		30. Name and address of person							n amotre	ADVI AND 017/0
ク	`		EDWARD W. DITT	1 22	M.D., I		CHARD TE	RRACE ROA	AD, HAGE	RSTOWN, M	ARYLAND ZI/4Z
	Sta Regist	ate rar	31. Date filed (Month 2	9 2004	Aleen	M. A	Jack				

			For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artment of rtificate of	Health a f Death	and Me	ental Hygie Reg	ene2004	353	41
	Physici	213	1. Decedent's Name (First, Middle	e, Last)						2. Date of Death		3. Time of D	
	/Medic	al	Carol Moffitt		umbor)		4b. City, Town,	1		Oct. 16,	4c. County of De	9:00	Ам
	Examin	er	4a. Facility Name (If not institution Carriage H		unio a r)			hesda	or Death		Montg		
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday		r If Under 2	24 Hrs. 8	B. Date of Birth (Month, Day, Y	9.8	irthplace (State or I	Foreign
	Director		577.22.8391	1□ M 2 🛣 F	86	Yrs.	Wortus Day	110013	A	ugust 12	2, 1918 B	altimore	,MD
	land ow		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town or L	ocation	-				10d. Inside City	Limits
	Mary B-1 eh	tor	MD Mon	tgomery		Che	vy Chase					1 ☐ Yes 2	2 (XNo
	ith the	Director	10e. Street and Number		"		10f. Zip Code			10g	. Citizen of What C	Country?	
	s 23a	srall	8100 Connection	ut Avenue				0815	===2 /C====	7. Van as Na	U.S.A.		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23e or 28e-f ehow reumetic event, the Medical Evernment mast be redified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	ried Armed F	orces? 2 📉 No live	in U.S. 13.	Was Decedent of If Yes, specify Cu		gin? (Speci i, Puerto Ri	ican, etc.)	Black, Wh	ite, etc.	
21215-0036	2 hour	ted t	15. Deceder	nt's Education			edent's Usual Occ			16	b. Kind of Busines	s/Industry	
215	thin 7. e. en "n	Completed	(Specify only highe Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of work don DO NOT use retii	e during most red)	t of working	7			
2	lled wi lygien her th		17. Father's Name (First, Middle,	(act)			Secretar		eta Nama /	Na First, Middle, Ma	tinal Ga	llery of	Art
Maryland	d be fi	o Be	Belford Hu					is. Mothe		erine Mc			
ary	shoul nd Me i mark umeti	L _O	19a. Informant's Name/Relations			19b. Mail	ing Address (Stree	et and Numbe			ity or Town, State,	Zip Code)	
2	and 2		Melville Moffi	tt/ Husba		8100	Connect	icut Av	venue	#1122 C	hevy Cha	se. MD 20	0815
Baltimore,	or oth		20a. Method of Disposition 1 □ Burial 2 X Cremation	3 □Removal from	State	Db. Place of Disp cemetery, cre	osition (Name of matory or other p	lace)	Dat	te 20	c. Location - City o	r Town, State	40
≣	t. Pag tment rtent: njury		'4 ☐ Donation 5 ☐ Other (S	Specify)	M		ort Crem				exandria r's Sons		
Ba Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic es once.		21. Signature of Funeral Service	Licensee			130 Wisc					, inc.	
			23a. Part1. Enter the disease, o shock or heart failure. List	r complications that conly one cause on	caused the each line.	death. Do not en	ter the mode of d	ying, such as o	cardiac or i	respiratory arrest		Approximate Interval Betwe Onset and De	en ath
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				cinomato	sis				6 months	
	Examiner					\mathbf{f} the \mathbf{B}	ladder					1 1/2 ye	ears
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a cor	sequence of):							
	ecuted and -transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	/05 55 5 005	, , , , , , , , , , , , , , , , , , ,							
8760,	cate be executed physician and s the burial-transit	ai E	,	. Due to	(Or as a COI	sequence of):							
687		edicai		d.									
Вох	death certifi e attending I id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or 1⊟Live	utcome of problems		∃Ectopic pregnan	cv			23d. Date of de	,	
о. Ш	0 0 0	/sici	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∏Preg 9☐Unki	nant at time nown		Other (specify)				Month	Day Yea	ar
٥.	de de	/ Ph	Part II. Dther significant conditi	ons contributing to	death but not	t resulting in the (underlying cause g	iven in Part I.		23e. Did tobac	co use contribute	to the cause of dea	uth?
Records,	quires n sign uld be									1 ☐ Yes	2 No 3 P	robably 4 DUni	known
000	e law requ has been je 2 should	Completed								24a. Was an		utopsy findings av	
		Com								autopsy performed 1 Yes 2	d? death? INo 1 ☐ Ye		se oi
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:						Check only one)			
ō	Phye this al dii	: To	1 ☐ Yes 2X No 27. Manner of Death	11	Inpatient of Injury oth, Day Yea	2 ER/Outpatie	III OLI DOA			5 Residence d. Describe how	e 6 □Other (Speiniury occurred	ecity)	
<u>0</u>	nding Fath. r: After e funer	atior	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	ng (Moi igation	nth, Day Yea	(r) Injury	W	ork? ⊒Yes 2 🔲 N	No		. ,		
Division of	si or Attendir s after death. I Director: Al d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Plac	e of Injury - ding, etc. (Sp	At home, farm, st	reet, factory, office	Э	28	f. Location (Stree City or Town, S	at and Number or F	lural Route Numbe	r,
	urs aff urs aff srel Di		X 2 1/1										
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier f Certifyii (Check only 2 Medicel one)	ng Physicien: To th Examiner: On the l and mai	ie best of my basis of exar nner stated.	knowledge, dea mination and/or it	th occurred at the ovestigation, in my	time, date and opinion, deat	d place, and th occurred	d due to the caus at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)	
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Me	29b. Signature and title of ertifie	11			29c. Licer	nse number		29d.	Date signed (Mon	th, Day, Year)	
)	6		1 / hece	200 am	2	MD)13187		0c	t. 19, 20	004	
			30. Name and address of person J. Neill Kenned		5530	(Item 23a) (Type Wiscons:	Print) Ln Avenue	e #1400) Chev	y Chase	, MD 2081	L5	l
	Sta Registr		31. Date filed (Month, Day, Year, OCT 22		Registrar's S	- 20	Spark	21					

			For State	State of M		epartment of I	Health and		iene nn L	35342
	•	40	Registrar 1. Decedent's Name (First, Middle,	Last)		ortificate of	Dealii	2. Date of Dear	eg. No.	3. Time of Death
	Physici		Alexander De	_	Nunez			Month October	Day Year 19,2004	
	/Medic Examir		Alexander Ros 4a. Facility Name (If not institution,			4b. City, Town,	or Location of De		4c. County of De	
90	*		3212 Spartan Rd.	#29		01n			Montgome	ry
	Funeral		5. Social Security Number 212–30–2220	. Sex 7. Ag	ge (In yrs. last birtho 77 Yrs	Months Days		in (Month Day	Year) 9. B	irthplace (State or Foreign Country) Da
Η.	Director		Usual Residence of Decedent	Α	//	3.		Dec. 25	, 1926 Cu	ida
	yland how		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e Mar ia-f sl	ctor	Maryland Montgo	nery	01ney					1 X Yes 2 □ No
	within 72 hours after death with the Maryland ane. than "natural", or Items 23c or 28a-f show he Mydfed Exam ar must be mailful at	Dire	10e. Street and Number	#20		10f. Zip Code		1	0g. Citizen of What (Country?
	sath v	eral	3212 Spartan Rd	12. Was Decedent	Everin II C		0832	/O	USA	to to the
10	iter de	Fun	11. Marital Status 1 □ Nøver Married 2 ☑ Married	Amped Forces	No 1952-	13. Was Decedent of If Yes, specify Cub	_		14. Race - An Black, Wh	
036	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1954	1 ∆ Y <i>e</i> s 2 □ No	Specify: C	uban	Specify: Ca	ucasian
21215-0036	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)	(0	ecedent's Usual Occu	during most of v	workina	16b. Kind of Busines	s/Industry
121	within ne.	mp	Elementary/Secondary (0-12)	2 Yrs.		fe. DO NOT use retire .anner	nd)		77 1	
2	filed v Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, La			.aiiiei	18 Mother's N	Nam <i>e (First, Middle, I</i>	Hotel	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or flems 23s or 28a-f show are injury or other traumatic event, the Mydical Excitions must be rediffed at once.	o Be	Laureano Nunez					ria Rosa (,	
ary	and N	_	19a. Informant's Name/Relationship	(Type, Print)	19b. M	lailing Address (Street	and Number or	Rural Route Number	City or Town, State,	Zip Code)
Σ,	and 2 ealth m 27 I		Graciela Nunez-	Wife	321	2 Spartan	Rd. #29			
Baltimore,	Tof H		20a. Method of Disposition 1 Surial 2 Cremation 3	☐Removal from State	cemetery,	isposition (Name of crematory or other pla			20c. Location - City o	
ţ	t. Partmen	. /	'4 □ Donation 5 □ Other (Spe	cify)	Quant	ico Nat'l	1	/25/2004 1 ines-Rinal	-	
Bal	Depar Impor any ir	(8	21. Signatur Funeral Service Li	w A	_					ng, MD 20904
		1	23a. Part1. Énter the disease, or co shock, or heart failure. List or	implications that cause by one cause on each I	d the death. Do not ine.	enter the mode of dyi	ng, such as card	liac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Nosocomia	1 Pneumoni	.a			22 Days
	/Medical Examiner		rosaking in doaling	Due to (or as	a consequ <i>e</i> nce of). Chronic O	bstructive	Pu1mon	arv Diseas	e	Unknown
	. %	eľ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of):					o inchown
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
o,	an an rial-tr	Exa	resulting in death) Last		a consequence of):					
8760,	icate be executed physician and s the burial-transit	cal		d.						
9	death certificate be executed e attending physician and nd for use as the burial-transit	Physiclan/Med	IF FEMALE:	000 16.000 0.400000						VI.
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 Ectopic pregnanc 5 Other (specify)	у		23d. Date of de Month	Blivery Day Year
o.	t the de by the a tached	iysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	it time of death	5 Uther (specify) _				
0	tha de		Part II. Other significant condition	contributing to death t	out not resulting in th	e underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w raquiras baan sign should ba	ed by	Congestive Hear	t Failure				1 □ Ye	s 2 No 3 F	robably 4 🖔 Unknown
ပ္ပ	aw re	Completed	History of Cere	brovascula	r Acciden	t		24a. Was ar	24b. Were a	utopsy findings available
Ä		Com						autopsy perform	ned? death? X No 1 ☐ Ye	completion of cause of s 2[X] No
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of \	Physician: this certific ral director,	은	1 ☐ Yes 2 📉 No		ent 2 ER/Outpa	tient 3□ DOA Oth	1er. 4 ☐ Nursing	Home 5X Reside		ecify)
On (tter ine	ion	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Tim uy Year) Inju	ry Wo	ryat rk? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	Attending r death. sctor: After by the funer	ertification;	2 Accident investigat 3 Suicide 6 Could no	be 28e. Place of In	jury - At home, farm	street, factory, office	163 5 140	28f. Location (Str	eet and Number or P	Tural Route Number.
Div	al or safter	Certi	4 Homicide	building, e	tc. (Specify)			City or Town	State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner st	of examination and/o	eath occurred at the ti r investigation, in my o	me, date and pla opinion, death oc	ice, and due to the ca courred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the Complei	Me	29b. Signature and title of certifier	11 -		29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
	5		Milton	Smith	M.D.		39737		October 2	1, 2004
			30. Name and address of person wt Milton Smith, M.				hington	DC 20307		
1 p	Sta Registr		31. Date filed (Month, Day, Year) OCT 22 20	32 Registi	rar's Signature	Sparks		···-		

Amend item 24a per mr 837 11-8-04 Wealth and Mental Hygiere 0 0 4 35343 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 6:30 P October 26 2004 Gordon Merritt Parks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X**M 2□ F 88 Yrs. Director 347-10-8819 28, 1916 Canada Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumetic event, the Medical Examiner roust be notified at 1 ☐ Yes 2K No Director Maryland Frederick Frederick the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 23a 7431 Willow Road, Unit 30 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. 1 MYes 2 □ No
If Yes, Give
Year or Dates:1934-63 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Colone1 U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Walter Parks Hazel Merritt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth T. Parks, wife 7431 Willow Road, Unit 30, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
importent: if ite
eny injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 10/28/2004 Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line.

Immediate Carse (Final disease or conditions) 106 East Church Street, Frederick, MD Approximate Interval Between Onset and Death ^{ju}hysician disease or condition Dheumon. resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying r a consequence of): Examine burial-transit that initiated events 4641 ed by the attending physician and detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Omiha. 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: 24 hours after death. Funeral Director: After this certifice Was c e referred to medical examiner? 25. Was c Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 lo 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours at To the Funeral D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline, III, MD, 300 West Ninth Street, Frederick, MD

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

NOV 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For #19a, per/f. Nome, of Maryland / Department of Health and Mental Hygien of State 11/3/04, E.T., WCHD 48 Registrar #8, per/f.home, 10/26/04, Certificate of Death E.T., WCHD Reg. No. Amended item 35344 Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** THOMAS RANIERI /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Atlantic General Hospital <u>Berlin</u> Worcester If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 3M 2□ F Director 130-07-4711 83 23/15/04 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits r then "naturel", or items 23e or 28a-f ehov the Medical Examiner must be notified at Director 1 Yes 2 □ No Md. Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Convention Hall Drive 21842 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 るがる 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 to Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "natto any injury or other traumatic event, the Musica page. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenence NYC Transit 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Joseph Ranieri Philomena Calantuano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Carnerine 107 Convention Hall Dr., _Risitano Ocean City, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Calverton Nat'1. ` 4 ☐ Donation 5 ☐ Other (Specify) Cem. 10-27Calverton, NY 21. Signature of Fundal Service Licenses 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Berlin, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OUIMONIVG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examines physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 PNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death.

Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only To the within 2 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Dey, Year) Physicier

Registrar

State

97-33

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert

31. Date filed (Month, Day, Year)

		-	for State Registrar	State of Ma	ryland / Depa <i>Cer</i> i	rtment of He tificate of D	ealth and M <i>Death</i>		en 2 0 0 4	35345
	Physicia	an	Decedent's Name (First, Middle, Lass NANCY	LEE	RAWLINGS			2. Date of Death		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		ובלומצט	4b. City, Town, or L	ocation of Death	22 6	4c. County of Death	Amdel
	Funeral Director		220-34-8260	ex 7. Age ☐ M 2 🗶 F	(In yrs last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, DEC. 29	9. Birtt Co. VI	nplace (State or Foreign untry) RGINIA
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	ation				10d. Inside City Limits
	Be-fs	Director	MD. ANNE AR	UNDEL	GLI	EN BURNIE				Yes 2 No
	with the a or 24		10e. Street and Number	DD AMOTE DD		10f. Zip Code	061	10	g. Citizen of What Co	
	death ms 23	Funeral	8081 BUDDING 11. Marital Status	12. Was Decedent Ev		/as Decedent of His Yes, specify Cuban	061 panic Origin? (Spe	ecify Yes or No-	U.S.A 14. Race - Ame	rican Indian,
920	permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, If a Medical Ever finial be notified at once.	by	1 Never Married 2 Married 3 Widowed 4 Moiroced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			, Mexican, Puerto i Specify:	Rican, etc.)	Black, White	e, etc. HITE
2-0	72 hor	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	ent's Usual Occupat	ion urina most of worki	na 1	6b. Kind of Business/l	
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/lan	should be ind Mental marked o	To B	HOWARD	LEE MOOF	Æ		MARY	DELLA :	TOLLEY	
Maryland	2 sho and I is me		19a. Informant's Name/Relationship (City or Town, State, Z	21001
	1 and Health tem 27		MARY ANN RAWLING 20a. Method of Disposition	GS/DAUGHTE	20b. Place of Dispos	ition (Name of	D		GLEN BUR	
mol	Pages nent of l		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		l	atory`or other place;	1	2-2004	BRENTWOOD,	MD.
Baltimore,	permit. Departmitmoporte Importe any inju		21. Signature of Funeral Service Licer	1. 11 (1)	22. CI	Name and Address	of Facility	ME & CRI	EMATORIUM.	P.A.
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused t	he death. Do not ente				DALE, MD.	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	C	onger	tive	heam	T	-arilme	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequen of):			,		
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þ	oe exec sian ar urial-ti		resulting in death) Last	Due to (or as a	consequence of);					
68760	tificate be executed ig physician and as the burial-transit	edical		d						
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Sio	ttendir death. ctor: Al	catle	2 Accident investigation 3 Suicide 6 Could not be		A h h		es 2 □No	295 i	and and Alice have a Civi	and Courts Alverts as
Division of Vital Records,	after of Direct Direct d in by	Certification;	4 Homicide determined	building, etc.	y - At home, farm, stre (Specify)	et, ractory, office		City or Town,	eet and Number or Ru State)	rai Houte Number,
_	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier Certifying Ph	ysician: To the best of niner: On the basis of e	examination and/or inv	occurred at the time estigation, in my opin	e, date and place, a nion, death occurre	and due to the care ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifier		1 - 15	29c. License	number	29	d. Date signed (Month	, Day, Year)
)			1	~ (mD	048	900	00	to be 1	5 , 2004
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, F	Print)	Dr., G	Jen B	1+inmi	mD 21061
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 2 20	32. Registrar	's Signature	Sparker	,			

			For State Registrar	State of Ma		artment of h <i>rtificate of</i>	Health and Mo Death		giene 0 (35346
	Physicia		Decedent's Name (First, Middle, Las DOROTHY MARIAH	REED				2. Date of Dea Month Octobe		3. Time of Death 5:25P. M
	/Medic Examin		4a. Facility Name (If not institution, give Washington Advent		al	4b. City, Town, o	Park		4c. County	of Death
**	Funeral . Director		5. Social Security Number 6. Se 219–82–6891	X 7. Age	(In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day OCL. 6,	1920	9. Birthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Example or must be multified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Endemed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Specan, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	1	e - American Indian, k, White, etc. y White
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land	uld be fi Aental H rked oti tic ever	To Be	17. Father's Name (First, Middle, Last) Mitchel	He	rbert		18. Mother's Name Inize	(First, Middle,	_	Quize
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Baltimore, Maryland	Pages 1 and of He ant: If item		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			matory`or other pla		2004		City or Town, State Ville, Maryland
Balt	permit. Departr Importa		21. Signature	Hank	ŽĮ ŽĮ	Name and Address Onald V. 100 Powde	Borgwardt Borgwardt r Mill Roa	Funera d Belts	al Home, sville,	P.A. Maryland 20705
	· ·		23a Part1. Enter the disease, or composhock, or beart failure. List only of	lications that caused to the cause on each line	he death. Do not en					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Vause (Final disease or condition resulting in death)	Sepsis						Criser and Death
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_	E 0 a		IF FEMALE:							
.O. Box	that the death certified by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 18 months? 1 Yes 21 No 9 Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	y		23d. Date Mon	e of delivery nth Day Year
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Vital Records,	The ate h page	Completed						24a. Was a autop: perfor 1 Yes	sy pr med? de	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No
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o	두 두 등	\vdash	1 ☐ Yes 21 No 27. Manner of Death	28a. Date of Injury	28b. Time o	" 3L DOA	4 Nursing Hom		ow injury occurre	
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)		M	29b. Signature and title of certified			29c. Licens 478		Ĉ	29d, Date signed October	(Month, Bay, Year) 21, 2004
	12		30. Name and address of person who	ompleted cause of dea	ath (Item 23a) (Type,	Print)				
	=40		ONEY Zaniga, M.I			d Rockvi	lle, Maryla	and 208	52	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 22 200	32. Begistrar	's Signature	Sparks				

			For State Registrar	State of Ma	aryland		artment of				giene Reg. No.	004	353	47
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath	Year	3. Time of	Death
	Physicia /Medic		Otto Josef Ruesch							Oct. 1	14, Day 20	004	7:15	РМ
	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town					ounty of Death		
			1 Primrose St. 5. Social Security Number 6. Sex	7 40	e (în yrs. la	at hirthday)	Chevy If Under 1 Yes	Chase		9 Data of Bird		ntgomer		
	Funeral Director		5. Social Security Number 6. Sex X	M 2DF	64	Yrs.	Months Day		Min.	8. Date of Birt (Month, Da) Oct. 5;	y, _{Year)} 1940	[:ai	place (State o intry) zerland	r ⊢oreign d
	D		Usual Residence of Decedent								, 25 10	3,12		
	nylan show		10a. State 10b. County	4		Town or Lo							10d. Inside Ci	•
	Ba-f s	cto	MD Montgome	- У	Cirev	y Chas								2 No
	with th		10e. Street and Number				10f. Zip Code	9			-	n of What Cou	intry?	
	s 23g	erai	1 Primrose St.	12. Was Decedent	Ever in 11 9	12.1	20815	f Hispania Or	rigin? (Spo	ody Voc or No	USA	. Race - Amer	ican Indian	
36	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jical Examinan must be mulfied at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2011 If Yes, Give Year or Dates:			Was Decedent of fYes, specify Ci 1 □ Yes ※ X□ N			Rican, etc.)		Black, White	, etc.	
8	2 hou		15. Decedent's Educ	cation		16a. Deced	dent's Usual Occ	cupation			16b. Kind	of Business/I	ndustry	
215	hin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	5+)	(Give life. L	kind of work dor DO NOT use reti	ne during mos ired)	st of worki	ng				
7	ad wit	Con	4	4		CEO o	f Ruescl					Busine	ess	
nd	be file	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Su	ımame)		
Z	d Men narka natic	٦	Otto Josef Ruesch	no Onios)		105 Maille	ng Address (Stre			Sauter	- 0' T		- 0 1 1	
, Maryland 21215-0036	and 2 sl ealth and m 27 is r nar traur		19a. Informant's Name/Relationship (<i>Ty</i> ₁ Jeanette Ruesch –		1001 71	1 Pri	mrose St		evy (Chase, N	MD 20	0815		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show any Injury of othar traumatic event, If e Medical Exertiner must be netitied at once.		20a. Method of Disposition 1 ☐ Burial ※☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	CO	netery, cren	sition (Name of natory or other p rt			-2004		tion - City or T ndria,		
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service License	90			. Name and Add			-		Sons : 20016	Inc.	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused be cause on each li	d the death.	Do not ent	er the mode of d	lying, such as	s cardiac c	or respiratory ar	rest,		Approximate Interval Bety	ween
	Pnysician		Immediate Cause (Final disease or condition	Metasta	atic I	ancre	atic Ca	ncer					13 mon	ichs
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								
	Ladillile	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as	a consequi	ence of):								
	ted nsit	nine	Cause (Disease of Injury	Duo 10 (6) as	a oonsoqu	01100 01).								
<u>,</u>	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):								
8760,	ysicia ysicia		d),										
9	rtifical ng ph as th	Medi	IF FEMALE.		***						1			
Вох	death certificate be executed e attending physician and od for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth	2 Fetal	death 3□	Ectopic pregnar	ncy			230	d. Date of delivers. Month		rear .
0.	the dea by the at ached fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of de	ath 5□	Other (specify)					MONTH	Day	eai
0			Part II. Other significant conditions con	tributing to death b	out not resu	lting in the ur	nderiving cause	given in Part	1.	23e. Did to	obacco use	contribute to	the cause of d	eath?
ds,	as as	d by		· ·			, ,	•		1 🗆 Y	res 2□N	No 3□Pro	bably 4 □U	Jnknown
Records,	S T 0	ompleted								24a. Was	an 2	24b. Were aut	opsy findings a	available
Re	9 4 9	omp									rmed?	prior to co death?	ompletion of ca 2□ No	ause of
Vital		Se C	25. Was case referred to medical					26. Place	e of Death	(Check only o	2 💢 No ne)	1 103	20140	
_	g .s .g	To B	examiner? 1 ☐ Yes 2 🔀 No	lospital: 1 🗌 Inpatie	ent 2 🗆 E	R/Outpatien	t 3 DOA	Other: 4 🗆 Nu	ursing Hor	ne 5 XResid	dence 6	Other (Speci	fy)	
n of			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	W			28d. Describe h	now injury o	ccurred		
sio	in at at in a	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2						
Division	or Attanater deatl	ertification;	4 ☐ Homicide determined	28e. Place of Inj building, et	c. (Specify)	ne, farm, str	eet, factory, offic	e	,	28f. Location (S City or Tow		iumber or Hur	ai Houte Numi	ber,
1	Hospital 14 hours Funaral tely filled	O	29a. Certifier 1 Certifying Phys	sician: To the best	of my know	rledge, death	n occurred at the	time, date ar	nd place. a	and due to the	cause(s) an	d manner as	stated.	
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Medical Examination)	ner: On the basis o and manner	f examinati	on and/or inv	estigation, in m	y opinion, dea	ath occurre	ed at the time, o	date and pla	ace, and due l	to the cause(s))
	To th withir To th	ĕ	29b. Signature and title of certifier	[1				nse number				igned (Month,	Day, Year)	
)	20		1 the	Me			MI	1718	45	(DC)	10	120/0	74	
			30. Name and address of person who co	mpleted cause of c		23a) (Турө, е N О . с	Print)	Wash	change	(DC)	C			
	Sta	te	31. Date filed (Monto Day, Year)	32. Registr	ar's Signati		B		0					
	Registr	-	OCT 2 2 200	14 Day	Epp. March	B	Moore	Esd						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death K. Rosensteel Frances Month **Physician** 6:45 P M October 30 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick County Northampton Manor Health Care Center Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1□M 2XF 216-07-5776 93 Yrs. Director 29, 1911 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other traumatic event, If a Medical Events are served. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Frederick County Frederick 1 X Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 East 16th Street 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White δ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) nurse nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Benjamin Ogle Grace Ellen Keilholtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Hain / niece 378 River Road Millsboro, Delaware 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Nov. 2004 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New St. Joseph's Cem. Emmitsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service Licensee 210 West Main Street Emmitsburg, MD 21727 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ALZHOMORS DOMONTIA years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of): Examiner | Records, P.O. Box 68760, A that initiated events resulting in death) Last Due to (or as a consequence of): physicien s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE. 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 🗆 No 2X No 1 TYes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 ☐ Yes 2 🗶 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 X Natural 1 Tes 2 No investigation 2 Accident Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 11104 D35111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 Frederick Street Richard L. Gough, M.D. Walkersville, MD 21793 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical 2004 JOHN ANTHONY RUTH Oct. 28, 7:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1117 Bernoudy Road White Hall Baltimore

Funera		5. Social Security Number 545-01-7642	6. Sex 7. Age (In yrs. last birth	Months	1 Year Days	If Under 24		irth Pay Year)	Birthplace (State or Foreign Country)
Directo		Usual Residence of Decedent		95 Yr				2/10	17303	California
/land		10a. State 10b. County	1	Oc. City, Town	or Location					10d. Inside City Limits
If I I I I I I I I I I I I I I I I I I	Funeral Director	MD. Bal	timore			Whi	te Ha	11		1 ☐ Yes 2 🛣 No
ith th or 28		10e. Street and Number			10f. Zip (Code			10g. Citizen of W	hat Country?
ath w	la l	1117 Bern	oudy Road				2116			ed States
er de Items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decedent Eve Armed Forces?	er in U.S.	 Was Decede If Yes, speci 	ent of Hi ify Cuba	spanic Origin n, Mexican, Pi	? (Specify Yes or Nuerto Ricen, etc.)	o- 14. Race Black	- American Indian, , White, etc.
urs aft	۾	3 Widowed 4 □ Divorced	ied 1 □Yes 2★ No If Yes, Give Year or Dates:		1 ☐ Yes 2	No.	Specify:		Specify:	White
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Te, INCLYIC S 1 and 2 should f Health and Mer liem 27 is marke other traumatic		David E. Rut			70 Oak					, Pa. 19038
s 1 au if Hea item othe		20a. Method of Disposition		20b. Place of D				10730		City or Town, State
Page Page Int: If		1 ☐ Burial 2 ♣ Cremation 4 ☐ Donation 5 ☐ Other (S	O Ma tottloval Holl State	ckess			1	2004	Hockes	sin, Delawar
permit. Pages 1 and 2 Department of Health a Important: If item 27 is		21. Signature of Funeral Service		1/2-11	22. Name and					e, Maryland
1 83E 5	3	11. Du	elelen Kw	13-11	E.G.	Ku	rtz &	Son Fu	neral H	ome, P.A.
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the only one cause on each line.	e death. Do not	enter the mode	of dying	g, such as care	diac or respiratory a	arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a Altz L	eime.	-15	de	me A	-		Onset and Death
/Medica Examine		resulting in death)	Due to (or as a c	onsequence of)						
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requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit	Physician/Medical	IF FEMALE:		Control for the control						
ath ca	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death	3 ☐Ectopic pre				23d. Date Mont	of delivery h Day Year
that the death	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death	5 ☐ Other (spe	cify)			No.	oay real
that the opposite of the oppos		Part II. Other significant condition	ns contributing to death but n	not resulting in th	e underlying cau	use give	n in Part I.	23e. Did 1	obacco use contrib	oute to the cause of death?
quires n signé	eted by					_		10	Yes 2 No 3	Probably 4 Unknown
aw require as been si 2 should to	lete							24a. Was	an 24b. We	ere autopsy findings available
The law ate has b	Compl								psy pri prmed? de	or to completion of cause of ath?
sician: The land transfer of t	BeC	25. Was case referred to medical					26. Place of D	1 ☐ Yes Death (Check only of		Yes 2 No
Physic this ce	10	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	tient 3 DOA	Othe		g Home 5 Resi		(Specify)
ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Tim	e of 28	c. Injury Work			how injury occurred	
tendi leath. tor: A	cati	2 Accident investig	ation		М	1 🗆 Y	es 2 No			
or At after of Direct in by	Certification	4 Homicide determi	28e. Place of Injury building, etc. (- At home, farm Specify)	street, factory,	office		28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,
spital ours a		29a. Certifier 1 Certifying	g Physician: To the best of m	v knowledge d	eath occurred at	t the time	date and nic	and due to the		
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical I	examiner: On the basis of ex and manner stated	amination and/o	r investigation, in	n my opi	nion, death or	ccurred at the time,	date and place, an	d due to the cause(s)
To th To th comp	Me	29b. Signature and title of certifier		1	29c.	License	number		29d. Date signed (Month, Day, Year)
		1 hole	9 2	1	O	00	3840	39	10-28.0	1
-		30. Name and address of person v		h (Item 23a) (Ty			2227		art 37	•
	6	John A.	R-M,	1 n.,	m. D	•	Bull	م سدمسره	ns 212	18
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4 1		, A			

Amend item#29d perill G83/ Flack Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Old Heistra MEND#25perME10/22/04, BWW, McOo Certificate of Death 1- For State of Wary Resistrate D#25per/E10/22/04, BWW, MoCO 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 0555A M am bor 10 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1) MMS DINOC more www oller If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 16,1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1**⊘**M 2□F 278-26-8816 83 Director West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f show in than "natural", or Items 23a or 28e-f shov The Medical Examinar is ust be notified at 1 Yes 2 XNo Director Maryland Montgomery Silver Spring 3118 Gracefield Road, #103 Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 United states Funeral 12. Was Decedent Ever in U.S. Anned Forces? 1 ØYes 2 □ No If Yes, Give WWII Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Department of NAVY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If flem 27 Is marked othe any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Samborski Agnes Bobak 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3118 Gracefield Road, #103 Silver Spring, Md. 20904 Ida Mae Samborski -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1K Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery | 10/25/2004 | Cheltenham, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Fane at Service Licenses Bonard V. Borywardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only/one cause on each line. Approximate Interval Between Onset and Death hemormage Intracranial Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit CERTIFICATION APPENDED BY MINISTER TEMPERATE Due to (or as a consequence of): attending physician Physician/Medical the as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq 2⊠No 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2/X No 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient ² 1X Yes 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28d. Describe how injury occurred 27. Manner of Death 28a, Date of Injury 28b. Time of 28c. Injury at Work? Certification: After Injury 5 Pending investigation 18 2004 1 Natural 800 P 1 ☐ Yes 2 X No bathroom 10 2 Accident after death the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 3118 GRACE FIELD ROAD within 24 hours a To the Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely 29b. Signature and bit 10/19/2004 29c. License number

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

22

2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

6

22S. Greene Street Baltimore, Maryland

Dacker

of death (Item 23a) (Type, Print)

32. Registrar's Signature

		1	State of Maryland / Department of Health and No. State Registrar State Certificate of Death	Mental Hygiena 004 35351
			I. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
	Physicia /Medic		GEORGIA M STRAND	10 22 .2004 1139 PM
	Examin		Ia. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year)
	Director		229 46 0320 1 M 2 F 67 Yrs. Months Days Hours Min.	Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Country
	D .		Jsual Residence of Decedent	
	nylan thow	_	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	a-f s	t5	md Balt Inove	Yes 2 No
	th th	Director	10e. Street and Number	10g. Citizen of What Country?
	23a	a	1209 PENN AUC 21216	United states
	eme eme	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc.
9	or It		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify:	Specify: 12) V
ö	72 hours after death with the Maryland neturel; or Iteme 23a or 28a-f show deat Examinat must be notified at	d by	3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
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ő	Depar Depar Impor any ir	6.5	Edgar K. Wharton 72171 Whonton	Ad Accomac VA. 23361
			23a. Part1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	
	Physician		Immediate Cause (Final	Onset and Death
	/Medical		disease or condition resulting in death) a. CERESIZITE VASCOLAR 14C Due to (or as a consequence of):	CIBERT
Н	Examiner		Sequentially list conditions b.	
+-	B ==	ner	Sequentially list conditions, large, learning to immediate ause. Enter Underlying Due to (or as a consequence of):	
	ocuted nd trans	Examin	Cause (Disease or injury that initiated events c.	
Ö,	be executed sician and burial-transit	ă	resulting in death) Last Due to (or as a consequence of):	
8760,	cate be executed physician and the burial-transit	dicai	d	
9		Me	IF FEMALE:	
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery Month Day Year
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<u>α</u>	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ds,	signe d be	d by		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 至 Unknown
Ö	w require been si should I	Completed		24a. Was an 24b. Were autopsy findings available
3ec	elaw has l je 2 s	mpi		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
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of	Phye this al dii	2	TE 163 22 10 FINALISM 2 EVOUDATION 3 DOX 4 INDISING IN	fome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
L C		ion	1 Matural 5 Pending (Month, Day Year) Injury Work?	
Division	or Attending after death. Director; After in by the fune	ical	3 ☐ Suicide 6 ☐ Could not be as a Place of Leight. At home farm street factory office	28f. Location (Street and Number or Rural Route Number,
<u>></u>	ospitel or A hours after uneral Direc ly filled in by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
	ite led		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	e, and due to the cause(s) and manner as stated. surred at the time, date and place, and due to the cause(s)
J	non non	Ü		
J	the Hosp nin 24 hou the Fune npletely fil	fedica	one) and manner stated.	20d Data signed (Mogth Day Veed)
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
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	To the Hosp within 24 hou To the Fune Completely fill	Medica	29b. Signature and title of certifier 29c. License number AU4176435 A	16012 10/22/2004
1.1	1.3	Medica	29b. Signature and title of certifier 29c. License number AU4176435 A	16012 10/22/2004

State of Maryland / Department of Health and Mental Hygien 2004 35352 Certificate of Death 3. Time of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 14: 15 M STALEY **Physician** JAMES 2004 26 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Hagerstown, Washington Avalon Manor Nursing Home Hours Months Days Hours Min. Jan. 15, 1958 Birthplace (State or Foreign Country)
 FL 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 215-76-9618 46 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County event, the Medical Examinations Da or 28e-1 show event, the Medical Examinations De notified at 1 XYes 2 □ No MD Washington Clear Spring, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 166 Cumberland St. 21722 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No II Yes, Give 1 Never Married 2 Married SpeciWhite 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) contractors Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 0 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event Be Cecil Newman Staley Carlene Elizabeth Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O.BOX 27 Clear Spring, MD 21722 Carlene E.Staley mother Oct. 28, 2004 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Speorly) 2 Cremation 3 Removal from State Clear Spring, MD Little Rose Hill 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722

Approximate 21. Signature of Funeral Se Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIRRHOSIS 0/ IVER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year signed by the atte Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 2**X** No certificate 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient this nerel Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural
2 Accident 5 Pending 1 Yes 2 No death. investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funerel Dire 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 104 D0058181 KODUAH PEPRAH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLEVELAND FRS JOUN SOUTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 29 2004 Registrar

1-	For State Registrar
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Case or 28a-1 show was be recipled at the particular at the partic	THOMA 4e. Fecility I 626 I 5. Social Se		SAPPINGTON, n, give street and number						2. Date of Deat Month OCTOBER	Day	Year 1004	3. Time of Death 8:50 A ^M
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-f show live at tor		2-8389	6. Sex 1 ▼ M 2 □ F	79	ast birthday) Yrs.	If Under 1 Months [Year It U		8. Date of Birth (Month, Day, MAR. 31	Year)	9. Birthp Coun MARY	lace (State or Foreign try) TAND
ish to	10a. State	ence of Decedent 10b. County	,	10c. City	, Town or Lo	cation					1	0d. Inside City Limits
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within 24 hours ariet dearn. To the Funeral Director: A completely filled in by the tu Medical Certificati	29b. Signat	1900				1	46	519		10-		

State Registrar 31. Date filed (Month, Day, Year)

OCT 2 5 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death

35354

Physician
/Medical
Examiner

For State Registrar

Funeral Director or 28a-f show

filed within 72 hours after death with the Maryland Hygiene. freumatic event, the Medical Exercises must be notified at ŏ "natural" and Mental Hygiene. Is marked other than permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other treumatic event
ang.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-transit been signed by the attending physician and should be detached for use as the burial-tran has been page 2 certificate funeral : After death. filled in by the Director:

The law requires that the death certificate be executed

Attending Physician:

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within 24 hours a

Division of Vital Records, P.O. Box 68760.

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER MICHAEL JAY SHAMA 2004 11:40A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Sept. 24, 1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 € M 2 ☐ F 58 Yrs. 216-50-5644 Indiana Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Beltsville 1 Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4213 Harbour Town Drive 20705 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐ Yes 2 ☐ No If Mes, Give Year or Dates: 1967–1970 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Specify: 3 Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) US ARMY CORPS of College (1-4or 5+) 5+ Elementary/Secondary (0-12) Civil Engineer 12 **ENGINEERS** 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) H. Rex Shama Jane A. DeRoo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) C. De Lene Shama -wife 4213 Harbour Town Drive Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MD National Mem. Park 10/23/2004 Laurel, Maryland Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland20705 21. Signature of Fungral Service Licensee 23a. Part1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final reno disease or condition resulting in death) o (or as a consequence of): the Extensive Lever Man Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 3 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2/X No Other: 1 X Locationt Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)/ 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) Takoma Park 31. Date filed (Month, Day, Year)

State Registrar

10

32. Registrar's Signature

2004

			1 - For State Registrar	State of Maryland /		artment of F			7111) 4	3535	5
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	lineale or	Dealii	2. Date of Death	g. Not.	7 7	3. Time of Death	_
п	Physicia	an		0 111				Month	Day	Year		4_
	/Medic Examin		Stephen Antho 4a. Facility Name (If not institution, give s		-	4b. City, Town, o	r Location of Deat	<u> October</u>	2 3 4c. County of	2004 of Death	2:45	P.
	LAdimii	iei	Frederick Memor			Frederi	ck		Fred	eric	k	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(ear)	9. Birthpl	ace (State or Foreig	n
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	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				10	Od. Inside City Limit	s
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	1 and Health em 27 ther tr		Jenise Smi 20a. Method of Disposition	20b. Place	of Dispo	sition (Name of	1	St. Frede	Oc. Location - (
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)				Oct.	28, 2004	Frede	vict	e md	
iii.	artme ortani injury		21. Signature of Funeral Service Lines	e // 01.7	22	2. Name and Addre	ss of Facility		San P		, , , , ,	
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Вох	death certifica attending plant of for use as t	M/us	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3「	Ectopic pregnancy	,		1	of deliver	*	
-	ed for	Physician/Me	in the past 12 months?	4☐Pregnant at time of death 9☐Unknown		Other (specify)			Mon	th [Day Year	
P.0	that the de ted by the a detached t	Phy	9 Unknown		a in the	- dashi'aa aassaa abs	as in Boot I	22a Did taha	and use contri	buta ta th	e cause of death?	
	g d	by	Part II. Other significent conditions con	4	-		en in Part I.	1 ☐ Yes	1	3 ☐ Proba		n
ör	w requir been si should	etec	SPINELP VCC-14	y sthouch	71-							
of Vital Records,	has has	Completed	sever lagra	25666616				24a. Was an autopsy performe	pr ed2 de	rior to com eath?	sy findings available pletion of cause of	0
<u>a</u>		e Co	25. Was case referred to medical				26 Flago of Do	1 ☐ Yes 2 sath (Check only one	No 1	☐ Yes 2	≧□ No	
5	Physician: this certific ral director,	OB	axaminer?	ospital: 1 Inpatient 2 ER/	Outpatier	nt 3 DOA Oth	05	dome 5 Residen	ce 6 ∏Othe	r (Specify		
1 0	g Ph)	⊥ :ս	27. Manner of Death		b. Time of		y at	28d. Describe how				
ior	auth. or: Aff	atio	1 Natural 5 Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		Yes 2 □ No					
Division	ter de irecto	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	r or Rural	Route Number,	
Ω	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		A CONTRACTOR OF THE CONTRACTOR	l-/	d			\\				
	Hosp 24 ho Fund Fund stely f	edical	29a. Certifier (Check only one) Check only 2 Medicel Exemination	icien: To the best of my knowled er: On the basis of examination and manner stated.	and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occi	e, and due to the cau urred at the time, dat	ise(s) and man e <i>a</i> nd place, ai	ner as sta nd due to	ted. the cause(s)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Med	29b. Signature and title of certifier	2.2		29c. Licens	e n <i>u</i> mber	290	d. Date signed	(Month, E	ay, Year)	
	- s - o		Juerren Co	Varies SA	,	H03	061117	7	10-2	4-0	4	
	_c um _a .		30. Name and address of person who co	mpleted cause of death (Item 23		Print) 400	W. 58	VEUM SS			7	
_	3		FRONCISCO A D	amels, Do		Frec	eenck	MP 2	1071			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		4 An	21/21	1				
	Registi	air	00120	בייין		- Jogo	and a					

			For Amend Item 25 State of Maryland, 609	ቀ <u>β</u> ቋባም <u>ዓ</u> ወ5ያ∱Health and N Certificate of Death		en 2 0 0 4	35357
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physicia		James Douglas Williams		Oct. 2	27 2004	08:27 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Examin	<u>.</u>	1521 Kensington Drive	Hagerstown		Washingto	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign
	Director		219-14-6104 1 [™] 2□F 81 Yr	s. Months Days	05/12/19	23	MD
	D .		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	or Location			0d. Inside City Limits
	anyla shov	2					1 ☑ Yes 2 ☐ No
	28a-1	Director	MD Washington Hager:	10f, Zip Code	10	og. Citizen of What Cour	ntrv?
	with t	古					,
	eath	erai	1521 Kensington Drive 11. Marital Status 12. Was Decedent Ever in U.S.	21742 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	US 14. Race - Americ	
30	be tiled within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or itams 23a or 28a-f show adent, the Madical Examiner must be notified at	by Funerai	Armed Forces? 1 ☐ Never Married 2 ☒ Married	If Yes, specify Cuban, Mexican, Puerion 1 Tes 2 No Specify:	Rican, etc.)	Black, White, Specify: Wh:	_{etc.} ite
15-0036	"natura	Completed I	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	king 1	6b. Kind of Business/In	dustry
7	within ene. then	m.	Elementary/Secondary (0-12) College (1-4or 5+)	lity Control Superv	risor	Aircraft	
ק ס	Hygie Hygie Sthar ant, III	ပိ	17. Father's Name (First, Middle, Last)		e (First, Middle, M	faiden Sumame)	
<u>a</u>		To Be	John William Williams, Sr.	Carrie	Elizabet	h Rotruck	
Maryland	d 2 should be th and Menta the substraints of traumatic av	-		Mailing Address (Street and Number or Run 21 Kensington Drive,			
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other tr	li	1 ☐ Burial 2 TyCremation 3 ☐ Removal from State cemetery,	crematory or other place)		20c. Location - City or To	
<u>=</u>	그 든 본 분		4 □ Donation 5 □ Other (Specify) Smiths 21. Signatur → Fun-ral Service Licensee	burg Cremator. 10/2			
Ba	Depa Impo any in		man X Kan	305 N. Potomac Str			
			23a. Part. Enter the disease, or complications that caused the death. Do no shock, or heert failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Inset and Death
æ	Physician	6 9	Immediate Cause (Final disease or condition	A RIERY DIS	EASE		VEFIRS
	/Medical Examiner	4	Due to (or as a consequence of	BOWEL DISE	255	/	EARS
		Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) _ //	174	7	
	scuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of	SURICIEIVCY			1 FAIRE
8760,	licate be executed physician and s the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of	E HEART HAI	VRE		JEARS-
687	ificate g phy: as the	edic			170		1
Vital Records, P.O. Box	The law requires that the death certifithes been signed by the attending tage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>م</u>	that the	Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ords,	w requires (been signe should be		ANEMIA		1 🗆 Ye	s 2 DNO 3 □ Prob	pably 4 Unknown
Reco	ysician: The law r is certificate has be director, page 2 sh	Completed			24a. Was an autopsy perform	prior to co	psy findings available impletion of cause of
ital		Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one	9)	
\$	Physic this ce al direc	To	1 Yes 2XXIo Hospital: 1 Inpatient 2 ER/Outs		1777	nce 6 ☐Other (Specia	(y)
n of	Attanding Physician: r death. ector: After this certific by the funeral director,		27. Manner of Lath 1 Loral 5 Pending 28a. Date of Injury (Month, Day Yeer) Injury	jury Work?	28d. Describe ho	w injury occurred	
Sio	tandii eath. or: A the fu	cati	2 Accident investigation	M 1 Yes 2 No	204 Leasting /Ctr	reat and Number of Bur	al Pauta Number
Division	for Attanated after deat Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined	m, street, factory, office	City or Town	reet and Number or Rura , State)	ar noute ivantoer,
	Hospital 4 hours Funaral ely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, 2 Medicel Examiner: On the basis of examination and land manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as sate and place, and due to	stated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	_	d. Date signed (Month,	Day, Year)
			> 1/Wahi 1/1/0512	1)0022043	S	10/28/	04
١ . ١	4.81		30. Name and address of person who completed cause of death (Item 23a) (1	Type, Print)			
9	`		Dr. Dwight Wooster, 11110 Medical	Campus Rd., #130, H	lagerstown	n, MD 21740	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 8 2004 32. Registrar's Signature	South			
			OU. NO COUT MANAGED TO				

State of Maryland / Department of Health and Mental Hygiene 2004 35

	1 - State Registrar	Ce	ertificate of Death	Reg	g. No.	35358
Physician	· ·	Sylvia WURTZEL		2. Date of Death Month October	20, 2004	3. Time of Death 8:45 P M
/Medical Examiner			4b. City, Town, or Location of Dea		4c. County of Death Montgome	
Funeral Director	5. Social Security Number 099-09-4884 6. Se	7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hr Months Days Hours Min		Year 9. Birthy 1912 Pol	place (State or Foreign ntry) and
Maryland -f show	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	10c. City, Town or I	ocation			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
5 after death with the Ma or Items 23a or 28a-1s ninst must be notifies Funeral Directo	10e. Street and Number 5901 Montrose Road	#1005 C	10f. Zip Code 20852		g. Citizen of What Cour Inited Stat	•
DESIGNOTE, MARYIGANG 21215-U035 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or puher traumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes & Vi No If Yes, Give^4 Year or Dates:	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2☐ No Specify:	Specify Yes or Norto Rican, etc.)	14. Race - Americ Black, White, Specify:	
27215-0036 ed within 72 hours at ygiene. ver than "natural", or ver than "natural", or ver than "Completed by F	15. Decedent's Edu (Specify only highest grad	e completed) (Giv College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of w DO NOT use retired) VNCT	orking 16	Grocery S	,
be filed tal Hyger double ovent,	17. Father's Name (First, Middle, Last)	n.1		ame (First, Middle, Ma	aiden Sumame)	
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth rtraumatic event To Be C	Aharon Yosef 19a. Informant's Name/Relationship (7)		Gitte ling Address (Street and Number or F	1 Mariam T		Code)
md 2 salth ar 27 is ar trau	Ethel Roth, Daugh		B Mary Cassatt Dr			854
Baltimore, permit. Pages 1 a Department of Hea Important: if Item any injury or othe once.	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify)	20b. Place of Disp cemetery, cri	position (Name of ematory or other place)	Date 20	oc. Location - City or To	
Departm Departm Importa any inju	21. Signature of Funeral Service Licens	be :	22. Name and Address of Facility Corchinsky Hebrew		Fairview, l ome	NJ
cate be executed have cate by sician and have burian-transit the burian-transit cate by the burian and cate burian-transit cate by the burian cate burian and burian	shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evenits resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Heart forlunk	Washin ic or respiratory arres	gton, DC	Applroximate Interval Between Onset and Death
The Colds, F.C. BOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 24 No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
dS, F.	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	
Physicien: The law requires the certificate has been signed in director, page 2 should be completed by				24a. Was an autopsy performe	prior to cor	psy findings available mpletion of cause of
sician sician sicertifi lirector	examiner?	lospital: 1 Inpatient 2 ER/Outpatie		ath (Check only one)	ce 6 ⊡Other (Specify	
for Attending Physician: I after death. In by the funeral director, for the funeral director, for the funeral director, pertification: To Be Co		28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how		<i>(</i>)
tel or Attending P rs after death. al Director: After ed in by the funers Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer Medical Certification.		isician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occurred.	e, and due to the causurred at the time, date	se(s) and manner as st e and place, and due to	tated. the cause(s)
To the Comp	29b. Signature and title of certifier	Alette	29c. License number 29c. License number		Date signed (Month,)	*
.)		empleted cause of death (Item 23a) (Type	, Print)		VV	
	Howard S. Goldste	in, M.D., 4701 Rand	olph Road, $#105$,	Rockville,	, MD 20852	2

State of Maryland / Department of Health and Mental Hygiere 35359 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 1:40 A^M Tammy May Waters October 15, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 20XF Yrs. Director 213-80-2120 36 13, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits inal", or Items 23a or 28a-f show Director 1 ☐ Yes 2 XNo <u>Oregon</u> Benton <u>Corvallis</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 97330 675 NW Linden Avenue USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry l Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 11 (UNK) Pages 1 and 2 should be filed in the sould be filed in the sould b 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Linda Sue Bowles 2 Ronald Leo Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya Benham/sister 675 NW Linden Avenue Corvallis, OR 97330 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 22. 5 = 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Arundel Crematory Odenton, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEP515 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ALCHOLIC Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death
Natural
Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of After 28d. Describe how injury occurred 5 Pending after death. death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 D50545 60 GODSWILL O. OKOJI MA. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 HAMPSHIRE TAKOMA PARK State 25 said ! Registrar

State of Maryland / Department of Health and Mental Hygien 2004

35360

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician OCT. 23,2004 5:20 A.M. CLYDEWOOD /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCEBRADFORD OAKS NURSING CENTER CLTNTONGEORGE 8. Date of Birth 5 (Month, Day, Xear) 5 / 8 / 1 9 20 If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign P A Country) **Funeral** Days 1. M 2□ F Months Hours Min 225-16-6637 84 Yrs Director Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23s or 28s4 show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits MarylandPRINCE GEORGE CLINTON1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 *10410 MCGUIRE WAY* U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Å Yes 2 □ No If Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7: I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER BUILDING HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nont of Health and Mental ALLEN WOOD GENORY ATKINS BROOKS ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: if item 27 is any injury or other trat PATRICIA JOHNSON (daughter) 10410 MCGUIRE WAY CLINTON MD. 20735 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other plece) 1 Burial 2 □ Cremation 3 □ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) EBENEZER CHURCH 10/28/04 WARSAW VIRGINIA 22. Name and Address of Facility 21. Signature of Funerel Service Licensee BERRY O. WADDY P.O.BOX 305 LANCASTER VIRGINIA 22503 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or quence of) use ò Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. the 23b. Did tobscco use contribute to the cause of death? be detached signed by Yes 2□ No 3 Probably 4 □ Unknown þ should 24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? peen s Compl Jas page 2 certificate 0 2KNO 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? or Attending Physician: director, Be 26. Place of Death (Check only one) Other: Nursing Home Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After Certification: 1 Matural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end manner es stated.

Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner steted. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Yeer) 29c. License number 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 9 Kene 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

			1- State of Maryland / Dep Registrar Ce	artment of Health and I artificate of Death	Mental Hygiei Reg.	2004 35361
	Physici /Medi		1. Decedent's Name <i>(First, Middl</i> e, Last) Zelda Roxie Wagaman		2. Date of Death Month	3. Time of Death 3.1. 2004 0300 A M
)	Examir		4a. Fecility Name (If not institution, give street and number) Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Hagerstown	1	4c. County of Death Washington
	Funeral Director		5. Social Security Number 162-22-5890 Cusual Residence of Decedent 6. Sex 1 M 2 S F 7. Age (In yrs. last birthday, 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Yes	ar) 9. Birthplace (State or Foreign Country) PA
	Maryland -f show lied at	tor	10a. State 10b. County 10c. City, Town or L	ocation Iountain		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 28e	al Director	10e. Street and Number 11223 Loop Road	10f. Zip Code 17261	10g.	Citizen of What Country? USA
980	be filed within 72 hours after death with the Maryland ital Hygiene. Indicate than "natural", or Items 23a or 28e-f show event, the Madical Examinar must be motified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 hou ene. than "netura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation be kind of work done during most of work DO NOT use retired) To use deare.	king	Kind of Business/Industry
land 2	2 should be filed within and Menial Hygiene. Is marked other than 'raumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Harry Barnes		e Baker	ate hospital en Sumame)
	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic en once.		Gloria J. Smith daughter 7402	ng Address <i>(Street</i> and Number or Rul Creager Rd., Way	nesboro, P	
Baltimore,	. Pages t tment of H tent: If iter jury or oth		'4 Donation 5 Other (Specify)	matory or other place) S Cemetery Nov	3, 2004	Location City or Town, State South Mountain, PA
Ba	permit Depar Impor any ir		1 (Julium III Le III	O S. Broad St., W	aynesboro.	
1	Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	Concer	or respiratory arrest,	Approximate Interval Batween Onsal and Death
68760,	tilicate be executed g physician and as the burial-transit	fedical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C			
.O. Box	The law requires that the death certate has been signed by the attendin bage 2 should be detached for use	by Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that the de been signed by the should be detached	ed by P	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		ouse contribute to the cause of death?
al Records,		Completed	Sepsis		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vital	ding Phy a. After this Juneral d	atlon: To Be	25. Was case referred to medical examiner? Yes 2 No	other: 4 Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how inj	
Divis	or Al	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury : At home, farm, str building, etc. (Specify)		City or Fown, Sta	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one Check one Check only one	restigation, in my opinion, death occurr	red at the time, date ar	nd place, and due to the cause(s)
)	wit To		29b. Signature and title of certifier Reviewe, MD	29c. License number 500 605	764 29d. D.	ate signed (Month, Day, Year)
	() Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, D. Romane 12931 Out 31. Date filed (Month, Day, Year) 32. Rasistrar's Signature	till And Itry	. md 2	1742
	Registra		NOV 0.8 2004 Seneral &	long the		

Wagaman, Zelda mR#H5167328

		-	For State Registrar			Marylar		artmen rtificate			and M		eg. No.	04	35362
	Physici		1. Decedent's Nam Sherry	e (First, Middle,	Last) Diane		Yette	r				2. Date of Dea Month October	Day	Year	3. Time of Death 6:42 P M
	/Medio Examin	er	8122 Ar	rowhead				Fr	eder	Location	of Death		4c. Cour	nty of Death rederi	ck
	Funeral Director		5. Social Security N 200-56-20)54	i. Sex 7 1 □ M 2 🙀 F	'. Age (In yrs. 40	/ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Oct. 23	, 1964	9. Birthp Cour Penn	place (State or Foreign htry) sylvania
	e Maryland e-f show	ctor	Usual Residence of 10a. State Maryland	10b. County Freder	ick		ty, Town or Lo							1	10d. Inside City Limits 1 ☐ Yes 2 ▼ No
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show amy injury or other treumatic event, If a Medical Exacting must be notified at an once.	ted by Funeral Director	3 Widowed	15. Decedent's	Year or Dat	ces? 2.[∰No	16a. Dece	1 ☐ Yes 2	2 No	Specify:		ecify Yes or No- Rican, etc.)	14. R	ace - Americ lack, White, cify: Whi	etc. te
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Mary	nd 2 shoulth and N 27 Is ma		19a. Informant's N J. Brooks				1	0	•			al Route Number Frederi			- /
altimore,	Pages 1 au ient of Hea nt; If item ry or othe		20a. Method of Dis 1 Burial 2 4 Donation	Cremation :	B □Removal from S	tate	Place of Dispo cemetery, crer derick	natory or of	ther plac				20c. Location	•	
Balti	permit. Departm Importa any inju		21. Signature of Fu		100e		22	. Name an	d Addres	ss of Facilit		uffer F	uneral	Home	, PA
8760,	be attending physician and water transit and ior use as the buriat-transit	icai Examiner	23a. Part Lorent shock, of was inmediate Cause disease or condition resulting in death) Sequentially list or fany, leading to incause. Enter Unde Cause (Disease or that initiated events resulting in death)	(Final on on on other or on other or ot	b	used the deal ch line.	BREA			g, such as		or respiratory arr	est,		Approximate Interval Between Onset and Death
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<u>α</u>	sign d be	þ	Part II. Other signi	ficant condition	s contributing to dea	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did tol	-		ne cause of death?
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	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 🔀	KNO			ER/Outpatien	-	-	er: 4□ Nu	rsing Ho		ence 6 🗆 O		y)
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Ω	urs after oral Direction by		4 Homicide	determin	building	g, etc. (<i>Speci</i> i	<i>(</i> y)					City or Town	n, State)		
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	4		30. Name and add	ress of person w	to completed cause	of death (Iter	50/ C	Print)	VEN,	TH S	r.	FREAM	NICK	MB	21701
	Sta Registr		31. Date filed (Mor	th Day Year)		gist ar's Signa	ature	6	100	uks	, '	FREAM	,		

			1 - State Registrar	epartment of Health and M Certificate of Death	Re	g. No 2004	35363
Н	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
3	/Medio Examir		Charles Richard Adams 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1000	4c. County of Deat	h
	LXaiiii	iei	Union Memorial Hospital	Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	(ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		235-60-7068 65 Yr				
	lanyland show		10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
	ours after death with the Maryla rel', or Items 23e or 28a-f show Examilier mast be motified at	Director	MD Baltimore Baltimo	re			1 Yes 2 No
	with th	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	ns 23	erai	3343 Paine Street 11. Marital Status 12. Was Decedent Ever in U.S.	21211		nited Stat	
(0	r iten	Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ No	 Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F 	Rican, etc.)	Black, White	
03	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f ehow elical Examiner man be notithed at	Ď	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates 61-67	1 ☐ Yes 2 No Specify:		Specify: Whit	e
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene. Item 27 is marked other than "natur other treumatic event, Ira Madical	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
/lar	should be nd Mental marked o	ToB	Ira L. Adams	Ethel Mar	ie Leheu	1	
Jan	2 sho			ailing Address (Street and Number or Rural			ip Code)
	1 and 2 Health em 27 ther tr		Mary Sullivan/Significant Other 334 20a. Method of Disposition 20b. Place of D			0 21211 0c. Location - City or	Foun State
nor	Pages nent of I int: If its		1 Burial 2 Scremation 3 Removal from State	crematory or other place) No	ov 9		
Baltimore,	- F # -	l	21 Signature of Funeral Service Licenses	22. Name and Address of Facility Cremation and Funer		eltsville,	MD
m	Depa Impo any ir		Lall Moores	Cremation and Funer 8717 Green Pastures		rnatives Baltimore	. MD
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on pach line.	enter the mode of dying, such as cardiac or	respiratory arres	it,	Approximate Interval Between
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,8760,	s be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
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Box (death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
B.	ne death the atte	sicia	in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
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ital	iician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death	-	ANO I LI LES	2019
of V	hys his I dii	ို	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 FER/Outpa			ce 6 □Other (Spec	ify)
	ding I	tion	27. Manner of Death Natural 5 Pending (Month, Day Year) 2 Accident investigation		8d. Describe how	injury occurred	
Division	el or Attending P s after death. al Director: After the ed in by the funera	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm.			et and Number or Rui	al Route Number,
	s afte el Dire ed in t	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospitel or , within 24 hours after To the Funerel Dire completely filled in E	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, d Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, ar r investigation, in my opinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
)	To with Com	N	29b. Signature and title of certifier Multiplication (Parameter Signature)	29c. License number 00054/03	3 /	Date signed (Month)	- 2011
	121		30. Name and address of person who completed cause of death (Item 23a) (Ty	De, Print), Adam And			
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	אייקוטן ז אווערי			
•	Registr	100	NOV 0 9 2004 Jane	Low You			

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 35364 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Michael A. Allen Day Month Vaar **Physician** 1353 PM NOVEMBER 04 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Horpital Baltimore N/AIf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth OCL 31, 1957 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 260-04-3990 XXM 2□F Georgia 47 Director Usual Residence of Decedent 10b. County N/A death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at MD Baltimore THYES 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3810 Falls Road 21211 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ∆Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Examination. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 75-77 1 ☐ Yes 2XXNo Specify: Specialhite þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Midas 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Allen Colleen Johnson ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Allen (Wife) 3810 Falls Road Balto, MD 21211 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Bafto/Wash Crematory 1 ☐ Burial 2 X remation 3 ☐ Removal from State 11/6/2004 Laurel, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility
Burgee—Henss—Seitz Funeral Home, Inc.
3631 Falls Road Balto, MD 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Due to (or as a consequence of). VARICES 4 weeks /Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐ Yes 2☐ No been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? page certificate 2[**X**No 1 Yes 1 ☐ Yes 2 No or Attending Physician: actor. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation i Diractor: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To tha Funarai I Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha h 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD AT 243 8946 - ES HOVEMBER, O4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAUTAM GULATI 201 EAST UNIVERSITY , BALTIMORE, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0 9 2004

State of Maryland / Department of Health and Mental Hygie 2004 35365 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MA8 HLBAN novimber UDREY 4006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMOR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) GILCHRIST VIZ 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛣 F 78 218-18-0919 JUNS 6 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 1 No BALTIMORE Funeral Director MARAGO 1022101 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code V.S.A AR 1881 40616 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 22 Married Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: if Item 27 is marked other than ury or other traumatic event, the M Homemaks 127RZ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARDIST JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICK monioni K. ALBAN 20b. Place of Disposition (Name of Baltimore, 20c. Location - City or Town, State ncv. 10 20a. Method of Disposition cemetery, crematory or other place) № Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) KNOOOLENEVERY 4006 22. Name and Address of Facility

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AL 21. Signature of Euneral Service Licensee FURRAL AND EMATION I. Wound. 21093 23a. Part1. Enter the disease, or complications. That ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wonths **Physician** CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-transit Due to (or as a consequence of) the attending physician hed for use as the burial 68760 Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 UNo
9 Unknown Month Year Day 5 Other (specify) 4 Pregnant at time of death been signed by the s should be detached 9 Unknown o ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ Records, 2 NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No page 2 this certificate has 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 2 of completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Division Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier 58303 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore no 21204 N. Charles W 6601 32. Registrar's Signature State Registrar

ALISAN

State of Maryland / Department of Health and Mental Hygieney 35366 For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ber Day Year **Physician** AN DER SON 2004 WILLIAM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore H I Mere Year If Under 24 Hrs. Chest ourt 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Hours Min. 03-9165 Lin land navy Director Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural", or Itame 23s or 28e-f show or other traumatic avent, the Mudical Exercities maintained to modified at Baltimore 1 Yes 2 XNo Maryland Balt invere by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes. Give 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ita 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 42 - 46 1 ☐ Yes 2 💢 o 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Folk Lift Driver ruck 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be William Anderson ere tha Martha Washington ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Middle Kiver MD 21220 Ct, Anderson Mark 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or once. Metro Cramatory 22. Name and Address of Facility
ACUID L- WILLIAMS 21. Signature of Funeral Service Licensee MD 21229 X 11651 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years **Physician** 0 arcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy 2L No 1 Yes 2 No 1 Tes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 □ No Be director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined n 24 hours after de he Funerel Directo eletety filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death Item 23a) (Type, Print) Trimble tello 6 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item 1 per phy amend item 17 18 per inf 838 12-3-04 vt. State of Maryland / Department of Health and Mental Hygrene 0 0 14

35367 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last)
Alireza Rafiee
Alireza Bakhtiari 2. Date of Death 3. Time of Death Rafiee Bakhtiari Day Year **Physician** NOV. 2004 8:45am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner Montgomery Village Rehab. Center Montgomery Village If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JAN 27, 19 Montgomery 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1927 230-41-8844 Director Iran Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show enty Injury or other traumatic event, The Medical Evantment result be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20078 Apple Dowre Circle 20876 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 📉 No Specify: Baltimore, Maryland 21215-0020 Specify: White ۾ 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Government 17. Father's Name (First, Middle, Last) 18. Montalan Michanon Esfandeari Be Ahmad Bakhtiari Mirzaahmad Rafiee Bakhtiari Mohtltela Esfandeari ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3137 Flanders Court Waldorf, Homer Bakhtiary/cousin MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/6/04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Dawn F. McDonald ²²Name and Address & Facility of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) e mzo cardial infare trans /Medical Examiner Examiner sightles mellitus signed by the attending physician and d be detached for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records. P.O. Box 68760. Physiclan/Medical Nearle Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yea 2 □ 100 3 ☐ Probably 4 ☐ Unknown ρ 24b. Were autopsy findings available prior to completion of cause of death? cete has been sig page 2 should t 24a. Was an autopsy performed? Completed certificete has 1 □ Yes 2 1 1 No 2 XV0 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) ဠ 1 ☐ Yes 2 ☐ No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medicai Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attandir nours efter death. neral Director: Af / filled in by the fu death. 21 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge death occurred at the films, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier LILLEZ MD November 8 2004 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) Germantium MD 20874 Doctor Drive 19529 20 NH 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

NOV 0 9 2004

			For State Registrer	State of Marylan		artment of F rtificate of			giene 004	35368
	Physici		1. Decedent's Name (First, Middle, Last)	V. Brady				2. Date of Dea Month NOV	8 Day 2004	3. Time of Death 7:55p M
ą.	/Medio		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, o			4c. County of De	ath
Ş.,			Pasadena Assisted		to a to to the form of the color	Pasa If Under 1 Year	adena Tif Under 24 H	rs. 8. Date of Birth		Arundel
	Funeral Director		5. Social Security Number 466-38-4731 Usual Residence of Decedent	7. Age (In yrs.)	Yrs.	Months Days	Hours Mi	in. JAN 2	9, 1918 of	irthplace (State or Foreign Country) DISTRICT COLUMBIA
	Aaryland f show led al	or	10a. State 10b. County Maryland Anne Arun		y, Town or Lo Glen	Burnie				10d. Inside City Limits 1 ☐ Yes 2X No
	r 28a-	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What (Country?
	23s o	al D	7975 Crain Hgwy	Apt. 313		1	.061		USA	
920	J within 72 hours after death with the Maryland jiene, Than "natural", or Items 23c or 28a-f show The Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	!. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cubin		(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh Specify: V	
21215-0036	Elementary/Secondary (0-12) College (1-4or 5+) Rus Driver PC Count									
d 2	the the	a)	17. Father's Name (First, Middle, Last)		Das 1	DIIVEI	18. Mother's N	lame (First, Middle,		Delioois
ylan	Q 22 Q	To B	William T. Finn	ey			Cat	herine Tr	igger	
Z	0 0 00 0		19a. Informant's Name/Relationship (Type Eugene Brady/husba:						r, City or Town, State. Burnie : N	
Baltimore,	0 -		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	may al from State	lace of Dispo emetery, cren	sition (Name of matory or other place)	ce)	Date	20c. Location - City of Baltimor	or Town, State
Balti	permit. Page Deportment of Important: if any injury or once.		21. Signature Funeral Service License	andle					land, Inc.	
		Dawn F. McDoriald 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final								
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8760	icate be exi physician a s the burial	edical	d.							
.O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 nNo 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	elivery Day Year
<u>a</u>	es that the igned by be detact	by Ph	Part II. Other significant conditions conti	ibuting to death but not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ord	v require been sig should b							- 1 □ Y	es 2 No 3 ∏ F	Probably 4 Unknown
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Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	spital:	55/0	Oth	The second of the second	eath (Check only on		Assisted
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	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C	29a. Certifier 1 Certifying Physic (Check only one)	cien: To the best of my kno or: On the basis of examinat and manner stated.	wledge, death tion and/or inv	n occurred at the tirvestigation, in my o	me, date and pla prinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)
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	\mathcal{U}		30. Name and address of person who com	pleted cause of death (Item	1 23a) (Type,	Print) Andical C	enter.	Carolitin		
	Sta Registr		31. Date filed (Month, Day, Year) 9 20	04 32. Registrar's Signa	ture &	poor	ds !	Corollon		

		•	State of Maryland / Department of Health and Mental Hygiene 3536	9
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) A L A N JOHNSON BLACKWELL 2. Date of Death Month Day Year NOVEMBER 07, 2004 9:18A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	M
	Funeral Director		GOOD SAMARITAN HOSPITAL S. Social Security Number 6. Sex 12-30-4498 16 M 2 F 7 Age (In yrs. last birthday) 17 Yrs. Age (In yrs. last birthday) 18 M 2 F 7 Yrs. Age (In yrs. last birthday) 19 Birthplace (State or Fore Country) Yrs. Wonths Days Hours Min. FEB 01, 1733 MARY LA	nign ND
	ne Maryland 8e-f show	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim 12(Yes $2\Box$ 1)	
98	d within 72 hours after death with the Maryland Jene. r then "natural", or Itema 23a or 28e-f show the Medical Exactings must be risaffied at	Funeral	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10g. Citizen of What Country? 10g. Citizen of What Country? 10g. Citizen of What Country? 10g. Citizen of What Country? 10g. Citizen of What Country? 10g. Citizen of What Country? 10g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 12g. Citizen of What Country? 12g. Citizen of What Country? 12g. Citizen of What Country? 12g. Citizen of What Country? 12g. Citizen of What Country? 12g. Citizen of What Country? 12g. Citizen of What Country? 12g. Citizen of What Country? 12g. Citizen of What Country? 13g. Citizen of What Country?	
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Baltimore	permit. Pag Depertment Important: I any Injury o once.		*4 Donation 5 Other (Specify) GARRISON FOREST 11-17-09 OWINGS MILLS MILE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN JR. FUNERAL HOM 22. Name and Address of Facility BROWN JR. FUNERAL HOM 23. Name and Address of Facility BROWN JR. FUNERAL HOM 24. Donation 5 Other (Specify) 25. Name and Address of Facility BROWN JR. FUNERAL HOM 26. Name and Address of Facility BROWN JR. FUNERAL HOM 27. A TO THE PROPERTY OF THE PROPER	
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8760,	Examine physician and burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
P.O. Box 68	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown	
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Division of Vital Records,	ding Phys h. After this funeral di	ToB	25. Was case referred to medical examiner? 1	
Divis	oltal or Attenurs after death	Certification:	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifier 29c. Certifier 29d. Date signed (Month, Day, Year)	
)	101 \		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	21
	Sta Registr		DAVID SCHAMP MD 3333 N. CALVERT ST SUITE 500 21218 31. Date filed (Month, Day, Year) NOV 0 9 7004	

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylar	-		nt of H		and Me		giene 0	04	353	370
			Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath		3. Time	of Death
	Physici /Medic		Leona	Κ.	Bie	15ki				1	Month	or 7	Year 2500	1 11.	G9PM
	Examin		4a. Facility Name (If not institution	, give street and nu					Location o	of Death	1000.7		inty of Death	/	
			Harbor Hos	pital 6. Sex	7 A //	In as birdle to 1	Bell	tim r1 Year	If Under:	24 Hrs. [0 D-1(D)	-	N/A		
	Funeral Director		5. Social Security Number 216–36–5459	1 M 2 F	7. Age (In yrs. 65	Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da lug • 28	1939	9. Birth Cou Mar	place (State intry) yland) or i-oreign
	ס		Usual Residence of Decedent											<i>y</i> 2 4 11 4 1	
	anylan show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside	
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	death ms 23	era	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. V	Was Dece			gin? (Spec	eify Yes or No-		Race - Ameri	ican Indian,	
9	after or item	Fur	1 Never Married 2 Marr	Armed Fo ied 1 ☐ Yes If Yes, Gi	2 No		f Yes, spe 1 □ Yes	4	Specify:	, Puerto R	ican, etc.)		Black, White		
003	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:								ocity: Wh		
<u>5</u>	filed within 72 hours after death with the Maryland Hygiene ther then "naturel", or Items 23a or 28a-f show ther the Medical Examinat must be notified at	Completed by Funeral Director	15. Decedent (Specify only highes	's Education it grade completed)		16a. Deced (Give	kind of wo	al Occupa ink done di ise retired)	urina mosi	t of working	g		f Busin <i>e</i> ss/Ir ern Wa		
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Maryland 21215-0036	Ments Ments arked	To	Paul W. Wali				 -			nevie		onczak			
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non	Pages nent of int: If it iry or o		1 Burial 2 Cremation 4 Donation 5 Other (S)		State	cemetery, cren ≥n Have	natory or c	other place	-	1 1- 12	-04	Glen E			v1 and
Baltimore,	2 5 2 5		at 0:		-	1 00			4 80 1114						/ Lanu
m	Department of the partment of	7.	23a Hart1. Enter the disease, or shock, or heart failure. List	Hain	MA	M _C	Cull	y-Pol	ynial	k Fun	eral H	ome P.	A.	J 2111	22
			23a Part1. Enter the disease, or shock, or heart failure. List	complications that conty one cause on a	caused the dear each line.	th. Do not ent	er the mod	de of dying	, such as	cardiac or	respiratory ar	rest,	лутал	Approxima Interval Be	etween
	Physician	4	Infimediate Cause (Final disease or condition resulting in death)	_a	remic	Bow		17:50	ase				_	Onset and) and C
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):									7
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	uted	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	c Pil	ne virv	mo	sen-	te vi	6	Arte	evu '	Ston	ncic		
Ö,	e exectian an		resulting in death) Last		(or as a consec	,	/	4.		•			, , ,		
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Вох	that the death certifit ed by the attending f detached for use as	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No	1 ☐ Live t 4 ☐ Pregr	ointh 2 Feta nant at time of c	al death 3	Ectopic p Other (st					1	Date of deliv Month	Day	Year
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S, D	es g be	by P	Part II. Other significant condition	ens contributing to d	eath but not res	sulting in the ur	nderlying o	ause give	n in Part I.		23e. Did to	bacco use co			
ord	w requir been si should	ted									1 🗆 Y	es 2 AuNo	3 Prol	bably 4]Unknown
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Vital		o Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 D0	Othe	r.		Check onlv or e 5 □ Resid		Oab (0	4.1	
of	g Phys er this eral di	n: To	27. Manner of Death	28a. Date		28b. Time of		28c. Injury Work			d. Describe h		Other (Special curred	(y)	
ior	Attending I or death. ector: After by the funer	atio	1 Natural 5 Pendin 2 Accident investig	jation	ui, Day 16ai)	Injury	М		es 2 🗆 N	No					
Division	f or Attendation of the death Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	of Injury · At h		et, factor	y, office		28	If. Location (S City or Tow		mber or Run	al Route Nui	mber,
	pitel ours a eret D		29a, Certifier 1 Certifyin	g Physician: To the	hast of my kny	Dividad death		at the time	n data and	d place an	d due to the e	2000(0) 201			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical one)	Examiner: On the b	asis of examina ner stated.	ation and/or inv	estigation	, in my opi	inion, deat	h occurred	at the time, o	iate and plac	e, and due to	o the cause	(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29	c. License	number			29d. Date sig			
ł			I then it	uang				RES	00		/	Voven	ber	7,2	004
()	W		30. Name and address of person	2 11 6	4 . 1 .			(n - +	D			Weven Mas	.1.	1 -1	100 m
	Sta	te	31. Date filed (Month, Day, Year)		LITH HA	hover	517	ret	DO	MIN	iore	Mai	ylah	9 2	217
	Registr	400	NOV O	9 2004	Garage	~ 19	1	oa A	1						

			State of Maryland / De 1 - State Registra MEND ITEM #8 PER FH C837 11/	parti	ment of H	ealth a Death	and M	Re	eg. No.		
	Physicia	an	1. Decedent's Name (First, Middle, Last) Mayer Betman	-				2. Date of Deat Month	Day	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	41	b. City, Town, or	Location o	f Death	Oct. 30	4c. County	9:00 a M	
	LXamii	Ç.	10005 Brookmoor Drive		Silver	Sp	ring	_	Mont	gomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	M	f Under 1 Year fonths Days	If Under :	24 Hrs. Min.	HIMOHHII. LARY.	-12-192 Yearh	4. Birthplace (State or Foreign Country) Wash., DC	
	Director		579-22-7943 1 MM 2 F 80 Yrs Usual Residence of Decedent	·-				Jan. 1,	1924	wasn., DC	
	yland yland		10a. State 10b. County 10c. City, Town or	r Locati	ion					10d. Inside City Limits	
	e Mar la-fst	ctor	MD Montgomery Silv	er s	Spring					1½ Yes 2 □ No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination instituted at once.	al Director	10e. Street and Number 10005 Brookmoor Drive	1	10f. Zip Code 20901	L		14	Og. Citizen of V United	What Country? 1 States	
	ter dea Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Never Married 2 ■ Married 1 ▼ Yes 2 ■ No 1942 ■	13. Was	s Decedent of Hises, specify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
21215-0036	ours aff	þ	3 Widowed 4 Divorced Year or Dates: 1946	1 🗆	Yes 2X No	Specify:			Specify	white	
2-O	72 ho 'natur	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	acedent live kind	t's Usual Occupa d of work done d NOT use retired)	ition <i>uring</i> most	of workir	ng	16b. Kind of Bu	siness/Industry	
12	within ane. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		<i>NOT use retired)</i> Duntant				Acco	ounting	
d 2	Hygir othar ant,	Be Co	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name	(First, Middle, N	Maiden Sumam	θ)	
/lan	Mental Mental arkad artic ev	To B	Hyman Betman			N	linni	e Blend	man		
Maryland	12 sho h and 7 Is mu trauma			_	^{Address (Street a} Lansdown				-		
	s 1 and 2 of Health ar itam 27 Is othar trau		20a Method of Disposition 20b. Place of Di	ispositio	on (Name of	1				City or Town, State	
ē	Pages ent of nt: If i		1 Burial 2 Y Cremation 3 Hemoval from State		ory or other place e Cremat	· 1	11/3	/04	Beltsv	ille, MD	
Baltimore,	permit. Departm Importa any inju		21. Signatur of Funeral Service Licensee		ame and Address			emation	Servic	96	
	⊄ □ = e o		23a. Part . Enter the disease, or complications that caused the death. Do not	933	3 Gist A	venue	Sil	ver Spr	ing, MD	20910 Approximate	
b			shock, or heart failure. List only one cause on each line.				oardiac o	respiratory arre	,	Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) Metastatic Chol Due to (or as a consequence of):		iocarci	noma				7 months	
	Examiner		Sequentially list conditions, b.								
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate caus. Due to (or as a consequence of): Cause (Disease or injury								
ı ص	execu an and rial-tra		that initiated events resulting in death) Last								
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physiclan/Medical	d								
9	leath certific attending pl	/Мес	IF FEMALE: 23c. If yes, outcome of pregnancy				-		22d Date	e of delivery	
Вох	death of atten	iclan	23b. Was decedent pregnant in the past 12 months? 1 \ \text{Ves} \ 2 \ \text{No} \\ 4 \ \text{Pregnant at time of death} \\ 4 \ \text{Pregnant at time of death} \\ 1 \ \text{Ves} \ 2 \ \text{No} \ \text{Ves} \\ 1 \ \text{Ves} \ 2 \ \text{No} \ \text{Ves} \\ 1 \ \text{Ves} \ 2 \ \text{Ves}		topic pregnancy ther (s <i>pecify</i>)				Mor		
0		hys	9 Unknown								
Vital Records, I	es pe	by	Part II. Other significant conditions contributing to death but not resulting in the	e under	rlying cause give	n in Part I.		23e. Did tob	_	ibute to the cause of death? 3 ☐ Probably 4 ☐Unknown	
900	e taw requir has been s je 2 should	Completed						24a. Was ar		Vere autopsy findings available rior to completion of cause of	
Ä	The ate h page	Com						perform 1 ☐ Yes 2	ied? d LXNo 1	eath? □Yes 2□No	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othe			(Check only one			
ot	Phys this al di	7: To	27. Manner of Death 28a. Date of Injury 28b. Time	e of	3 DOA 28c. Injury Work			ne 5 X Reside 8d. Describe ho			
ion	Attanding Ir death. actor: After	atlor	1 XNatural 5 Pending (Month, Day Year) Injur 2 Accident investigation			? ′es 2 □ N	10				
Division	P # # =	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	, street,	, factory, office		2	8f. Location (Str City or Town		er or Rural Route Number,	
1	Hospital 24 hours a Funaral I		29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, do	eath oc	curred at the time	e, date and	d place, a	nd due to the ca	use(s) and mar	nner as stated.	
	To tha Hospital within 24 hours a To tha Funaral I completely filled	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.	r invest	tigation, in my op	inion, deat	h occurre	d at the time, da	te and place, a	nd due to the cause(s)	
1	To t To t	Σ	29b. Signature and title of certifier		29c. License			29	d. Date signed	(Month, Day, Year)	
•	1		30. Name and address of person who completed cause of death (Item 23a) (Ty)	no Prin		56345	-		1.12	104	
	1011		Dr. Piyush Patel, 12001 Ferrara Ave			on, M	D 20	0901			
	Sta		31. Date filed Not Day 1992 2004 33 Begistrar's Signature 4		parks						
	Registr	ar		11							

			For State Registrar	State	of Marylar			t of He		Menta		ene .ND n	1	05076	
	B)		Decedent's Name (First, Middle, L.	ast)	<u>-</u>					2. Date	of Death	200	ear	Time of Death	-
	Physicia /Medic		Edna Mae Bevi	.11e						Nov		r 4, 200)4	8:30_a ^M	ı
	Examin	er	4a. Facility Name (If not institution, gi		umber)		4b. City		ocation of Deat	th		4c. County of			
			Maplewood Park P 5. Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	If Unde	Bethe	SCA If Under 24 Hrs	8. Date	of Birth			omery ace (State or Foreigi	<i>n</i>
	Funeral Director			X M 2 □ F	94	Yrs.	Months	Days	Hours Min.	(Moi	of Birth	(ear) 1910	Count	(y)	
			Usual Residence of Decedent							- 001		1710			
	anylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10	d. Inside City Limits 1√2 Yes 2 ☐ No	
	8a-f	ecto	MD Montg	omery_	В	ethesda		0-4-			100	Citizen of Mh	- Count		_
	with ti	吉	10e. Street and Number				101. 21	Code	<i>t</i> .		100	J. Citizen of Wh			
	eath	Funeral Director	9707 Old George	town Ro	ad cedent Ever in U	I.S. 13. V	Vas Dece	2081	panic Origin? (S	Specify Yes	s or No-	United 14. Race -			_
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7	filled v Hygie thar t		17. Father's Name (First, Middle, Las				ALL		8. Mother's Na	me (First,	Middle, Ma	iden Sumame)			_
yıana	ld be ental kad o	To Be	James Robert L	aFon					Selma	Edna	Wisd	lom			
ary	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked othat than "natural", or Items 23a or 28a-f show othat than "natural", or Items 23a or 28a-f show othat transmatle word, the Medical Evantural free notified at		19a. Informant's Name/Relationship	(Type, Print)			-							Code) 83002	
, Mar	and 2		LaFon B. Ward,	Daught					nes Dri					cson, WY	
ore,	of He		20a. Method of Disposition 1 XBurial 2 Cremation 3	☐Removal from		Place of Dispo cemetery, cren	sition (Na natory or	me of other place)	1	Date		c. Location - Ci	ty or Tov	vn, State	
Ĕ	Pag ment tant; I		* 4 □Donation 5 □Other (Spec	cify)	/ Ci	ltizens				/13/0	4	Clarend	on,	TX	
Baitimor	permit. Pages 1 and 2 Department of Health ar Important; If item 27 is any injury or other trae 2003.		21. Signature of Funeral Service Lice	ansee	Mai	R R	app	nd Address Funera Lst Av	al and (Crema ilver	tion Spri	ervices	209	10	
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	/Medical Examiner		resulting in death)		o (or as a consec										
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Õ	entifica ling pl e as t	Med	IF FEMALE:	220 16 400 0	utcome of pregn	0001				-					
X O D	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta gnant at time of	al death 3	Ectopic p	regnancy				23d. Date of Month		y Day Year	
o.	that the de ned by the a detached t	iysid	1 Yes 2 No 9 Unknow	9□ Unk		302	1011101 (0								
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r D	w requires t been signe should be										1 🗌 Yes	X□No 3	☐ Proba	bly 4 Unknown	1
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	The ate h sage	Com								1 🗆	performe	d? dea	th? Yes		
Vita	sician: The law certificate has b irector, page 2 s	Be (25. Was case referred to medical examiner?	11				7	26. Place of De	ath (Check	conly one)				
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Division of	I or Attanding Patter death. Diractor: After din by the funer	ficat	3 Suicide 6 Could not		ce of Injury - At h	nome, farm, str						et and Number	or Rural	Route Number,	_
2	al or s after Dira d in b	Certification:	4 Homicide	buil	Iding, etc. (Speci	rty)				City	or Town,	orare)			
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	edicai C	29a. Certifier 1 Certifying (Check only one)	eminer: On the	he best of my kn basis of examinanner stated.	owledge, death ation and/or in	occurred vestigatio	at the time	, date and place nion, death occ	e, and due urred at the	to the cau e time, date	se(s) and mann and place, and	er as sta d due to	ited. the cause(s)	
	Fo the vithin Fo the comple	Me	29b. Signature and title of certifier				29	c. License	number		290	I. Date signed (i	Month, E	ay, Year)	
	C > F 0		1	en	111	ク		D2625	9			Novem	ber	5, 2004	
	1		30. Name and address of person wh		/ / ~	т 23а) (Туре,	Print)								
_	_ J:		Dr. Ava Kaufman				ue,	103,	Bethes	da, M	D				
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 9 2004	132.	Registrar's Sign	ature	loon	1							
	regist	- 1		4	Y /	7 900	por cold	San San							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 35373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Richard Τ. Bieniasz Nov. 2004 2:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Montgomery 3128 Gracefield Road 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** ₩ 2□ F Director 72 472-32-1301 Usual Residence of Decedent May 4, 1932 Minnesota the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at MD Montgomery 1 Yes 2 No Director Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 2 any injury or other treumatic event. The Medical Examinat must be n 20904 3128 Gracefield Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? M☐Yes 2☐No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Local Government Community Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anton Bieniasz Felicia Bieniasz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Bieniasz, Wife 3128 Gracefield Road, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 11/3/04 Other (Specify) Beltsville, MD /22. Name and Address of Facility
Rapp Funeral and Cremation Services 21. Signature of Fungral Service Licenses an 933 Gist Avenue, Silver Spring, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lymphoma 21 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attanding 5 Pending investigation 1 X Natural death. 1 Yes 2 No nours after death.

neral Director: A
filled in by the fi 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

INX

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

32 Registrar's Signature

7525 Greenway Center; #215, Greenbelt, MD

30. Name and address of person who completed cause/of death/(Item 23a) (Type, Print)

Dr. H.T. Katzen

NOV 0 9 2004

31. Date filed (Month, Day, Year)

C35

State of Maryland / Department of Health and Mental Hygiene) 35374 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 4, Margery E. Breed **Physician** 2004 9:00 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Howard 16100 Patapsco Overlook Court Mt. Airy If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
June 10, 1928 6. Sex 9. Birthplece (State or Foreign **Funeral** Days 1□M ATTF Months Hours Min. 216-28-7416 76 Director Usuel Residence of Decedent 10c. City, Town or Location
Mt. Airy death with the Maryland 10a. State permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iteme 23a or 28e-f show eny njury or other traumatic event. Its Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits MD Howard 1 ☐ Yes 2 ☑ No Directo 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 21771 16100 Patapsco Overlook Ct. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XXIo Specify: Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: Specify: þ ¾ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Security 12th Loyola College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Henry Wheeler Emma Gertrude Perry ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 19a. Informant's Name/Relationship (Type, Print) Margery D'Valle (Daughter) 16100 Patapsco Overlook Court Mt. Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 11/08/2004 Pikesville, MD *4 Donetion 5 Other (Specify) Burgee-Henss-Seitz Funeral HOme Inc. 3631 Falls Road Balto, MD 21211 21. Signature of Funeral Service Licenses 23a. Pert1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Corticobasalganglion **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) the à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ficate has been sig v, page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 5 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending Accident ↑ Yes 2 No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 032543 naul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 STROMBERE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2004 Registrar

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State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Yeer **Physician** Muriel Chase November 4, Berry 2004 20:22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Shady Grove Hospital Shady Grove Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 GF Yrs. 064-14-7608 88 Director May 18, New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any highry or other treumatic excessions. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1√TYes 2 □ No Montgomery Director Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue #233 20877 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Martin Chase Winifred Williams Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21780 Mr. Charles W. Berry (Executor) 16032 Foxville-Deerfield Road Sabillasville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Srv 11/8/2004 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Sykesville, MD RANGARI FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, ND 21784 (410)-795-1400 21. Signature of Funeral Service Licensee Man o 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocardial **Physician** Acute minutes infaction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arting Coconary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Ш

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Wenk, M.D.

9901 Medical Center Dr., Rockville, MD 20850

	4	1 - For State of Maryland / State Registrer	Depa Cer	artment of Health and rtificate of Death		2004	35376
Physicia: /Medica		1. Decedent's Name (First, Middle, Last) Rosa Br	00	ke	2. Date of Death Month	Day Year	3. Time of Death 4.30 A M
Examine	r	4a. Facility Name (If not institution, give street and number) Harbor Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last the	oirthday)		. 8. Date of Birth	0.0	more City
Director		223038312 1 M 2 Ø F 96 Usual Residence of Decedent 10a. State 10b. County 10c. City, To	Yrs.	Months Days Hours Min.	2/7/19	08	VA 10d. Inside City Limits
the Maryla 28a-1 eho	Director	MD Anne Arunde1		Severn	100	. Citizen of What C	1 ☐ Yes 2X No
eath with		1204 Thompson Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	13.1	21144		US 14. Race - Arr	SA
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and 2 should and 2 should ealth and Men m 27 is marke ner treumetic				ng Address (Street and Number or R 210 Thompson Aver	ural Route Number, C	City or Town, State,	. Zip Code) Land 21144
permit. Pages 1 and 2 Department of Health a Importent; if item 27 is any injury or other tree		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	of Dispo tery, crer	osition (Name of matory or other place) ge Mem. Park 11	Date 20	c. Location - City o	
permit. Departr Import		21. Signature of Emeral Service Licenses Mo1319	22	2. Name and Address of Facility I Second Ave	Single enue, SW,	ton Funer Glen Bur	ral Home, P.A rnie, MD 2106
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/Medical licate be executed by physician and is the burial-transit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or consequence) C. Due to (or as a consequence)	s of):	ryocardial in	tarction		2 weeks
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To t With To t	Σ	29b. Signature and title of certifier Delamitton, A	n.D.	29c. License number A \$ 2 4 4 16 14 -		Date signed (Mon	ith, Day, Year) O4
20		30. Name and address of person who completed cause of death (Item 23a Social Son Hamilton 3001	Sou	the Homan Street.		Paryland :	21225
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	B	Sparker			

State of Maryland / Department of Health and Mental Hygien ?

			1 - State Registrar	-0	Cei	rtificate of Dea		Reg. Date of Death	No.	3. Time of Death
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	/Media	al	Milton 4a. Facility Name (If not institution, given	Emory	Barret	4b. City, Town, or Locat		November	4c. County of Death	
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			26 Chester Circl 5. Social Security Number 6.5		e (In yrs. last birthday)	Glen Burn		Date of Birth	Anne Arur	nplace (State or Foreign untry) MT
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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	r 28	lrec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	th wil	alD	26 Chester Circl	e		21060			USA	
	dea	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Specifician, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23e or 28e-f ahow importent: if Item 27 is marked other than "natural", or Items 23e or 28e-f ahow pray injury or other traumatic avent, Ite Medical Examine must be notified at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Marned 3 🛣 Widowed 4 ☐ Divorced	1 XYes 2 ☐ I If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Spe			Specify: Whi	.te
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	1 an Heal em 2	0. 4	20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,		osition (Name of matory or other place)	Date		c. Location - City or	
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Ħ	artme orten injur		21. Signature of Funeral Service Lice			2. Name and Address of F	the second secon			-
Ba	permit. Departr Import		- Michiel C	DUYLH M	0/4/5 1	Second Ave.	SW, Gl	en Burni	e, MD 21	061
- 3			23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that caused y one cause on each li	ne.					Approximate Interval Between Onset and Death
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DHMH 17 Rev 1/2001

Registrar

NOV 0 9 2004

	1	State of Maryland / Department of Health and M State of Maryland / Department of Health and M Certificate of Death	lental Hy	/gien Reg. N	711114	35378
Physician		Decedent's Name (First, Middle, Last)	2. Date of De Month Novemb	eath		3. Time of Death
/Medical Examiner	1	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Novemb		5, 2004 c. County of Dea	5:45 pm M
Examilier		Greater Baltimore Medical Center Towson		В	altimore	
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi (Month, Di			thplace (State or Foreign
Director		911, 28 dods 20, 20 ALE	JUNE 19	102	H WAS	1.a rotarily
and	-	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
death with the Maryland rms 23e or 28e-f show roust be notified at	5 0	Exchan Baltimore Locketsville				1 ☐ Yes 2% No
with the Mar or 286-1 s be notified	3	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Co	puntry?
h with	3	19 LockEtovine ROAD 31030			U.S.A	
6 sifer death v or Nems 23s	2	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit	
If timore, Maryland 21215-0036 Iltimore, Maryland 21215-0036 Init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene, ortent: if item 27 is marked other then "naturel", or Items 23e or 28e-1 show injury or other treumette event, the Marie Excurter must be notified at a. To Be Completed by Funeral Director	2	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 € No If Yes, Give 1 ☐ Yes 2 € No Specify:	,		Specify:	110-
21215-0036 ed within 72 hours af Vajene. Per then "naturel", or it, it a M. die. Extu.	3 -	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b.	Kind of Business	HILE Andustry
1215-(mithin 72 h	2	(Specify only highest grade completed) (Give kind of work done during most of work	ing	100.	Tuna 01 Ba041000	aasay
d with	5	Elementary/Secondary (0-12) College (1-4or 5+) Home ImpRovement	T	1	ONSTRU	roitor
land had be file sental Hyge other ic event.		17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle	e, Maide	an Surname)	
laryland 2121 2 should be filed within and Mental Hygiene. is marked other than eumetic event, train.	2	J. VICTOR BRIAN JR. IRIS	MAG	2,5	15536	130
Tar Tar and and is m	J	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Run</i>	al Route Numb	per, City	or Town, State,	Zip Code) 21030
G. Be, No. 1 and Health Health the the true the the true the true the true true true true true true true tru	_	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	300	Location - City or	Town State
DO DE LE LE LE LE LE LE LE LE LE LE LE LE LE		1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)	8,		~	M o d
altimor mit. Pages partement of the portent: if ite y injury or of		'4 Donation 5 Other (Specify)	0974		5525 HJ	F LIVENTYVO
Baltimo permit. Pages Department of Important: If is enty injury or once.	1	21. Signary of Funeral Service Licensee 22. Name and Address of Facility PEREFUL ALTER 3335 CRK	BERN T	JRA.	BUNDUS	10.21093
	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			0,000	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition brady our Mthmia				Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of)				
	_	Sequentially list conditions, if any leading to immediate b. <u>Myocardial Infarct</u> Due to (or as a consequence of):				
executed and and rial-transit		cause. Enter Underlying Cause (Disease or injury				
68760, C. firste be executed from and is the burial-transit	- > 0	that initiated events resulting in death) Last Due to (or as a consequence of):				
68760, ifficate be exception to a supply sicient as the burial-leafical Expenses.		esophageal Varices				
U = - u				-		
S, P.O. Box 6 es that the death certification by the attending to detached for use as by Physician/Me	200	IF FEMALE: 23b. Was decedent pregnant 1		1	23d. Date of de	,
O. B he dear the att	200	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown			Month	Day Year
15, P.O. I res that the de igned by the a be detached to by by the short by the short by the short by by significant of the short by the significant of the short by the significant of the short by the significant of the si	È	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did	tobacco	use contribute to	the cause of death?
ds, ires the signed dibe of	2	renal failure			\	robably 4 Unknown
Cord	בונו		24a. Was	s an	24h Were at	utopsy findings available
Il Record The taw requir cate has been s page 2 should	1	e.coli septic shock	auto	psy ormed?	prior to death?	completion of cause of
Vital F iicien: Th certificate rector, pag		25. Was case referred to medical 26. Place of Deat	1 Yes	one)	fo 1 Yes	2 No
of Vita hysicien: his certific: I director,		examiner?			6 ☐ Other (Spe	cify)
on of ding Ph h. After thi funeral floor.			28d. Describe			
ISION Attendir death. ctor: Af	3	2 Accident investigation M 1 Yes 2 No				
Division of Vital Records, tell or Attending Physicien: The taw requires the after death. To briector: After this certificate has been signed in by the funeral director, page 2 should be completed by		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To			ural Route Number,
Division of Vital Records, P.O. Box Hospitel or Attending Physicien: The law requires that the death certificate has been signed by the attending telly filled in by the funeral director, page 2 should be detached for use a first Certification. To Re Completed by Physician M.	0	29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause	s) and manner as	stated
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tr	Solba	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
To the within 2 To the complete	Σ	29b. Signature and title of certifier	- 7	29d. D	ate signed (Mont	h, Day, Year)
	3	Month Homel MD 1 005 808	_	l	1/6/07	
1041		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) May K Gosnell 601 Pavillon Me	st		Tai	NSON MD
State	9	31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u> </u>		100	1
Registra		NUV 0 9 2004 Server 10 Sporks				

			For State Registrar	State of Marylan	-	artment of Heartificate of De		ntal Hygien Reg. N	Z 11 11 14	35379
	o ·		1. Decedent's Name (First, Middle, La	ist)	^		2	Date of Death Month	ay Year	3. Time of Death
	Physicia /Medic		CAZEUL	(")000101	Box	200	7	KVSMBRR	H006 d	10:25 AM
	Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or Lo	ocation of Death	4	c. County of Dea	th
			GITCHEIL TOU	TER		10000		1		5900
г	Funeral			Sex 7. Age (In yrs.	iast birthday) Yrs.		f Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year	9. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent	5.1			2-1	10 E- 9P 103	4 11 16	R3/200
	yland how		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Be-fs	Funeral Director	MASSLAD GALTAN	2002	ARK	366,5				1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	ountry?
	s 23a	ral	9317 HAN K.	OFE KONO		3133	7-1		U.S.A	•
	item Item	nue.	11. Marital Status	12. Was Decedent Ever in U	.5. 13.	Was Decedent of Hispa If Yes, specify Cuban, I	Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 21⊡ No 3	Specify:		Specify:	Mr.
21215-0036	72 hours after death with the Maryland netural', or Items 23a or 28e-f show areal Examiner must be neitified at	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupation	on	16b. l	Kind of Business	Industry
215	within 7 ene. than "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	life.	kind of work done duri DO NOT use retired)	ing most of working			
	filed with Hygiene. other thar	Con	-28KEi		34	SARTURA	R			oms
nd	be file tal Hy d oth avent	Be	17. Father's Name (First, Middle, Las	~		18	B. Mother's Name (F	First, Middle, Maide	n Sumame)	
yla	should nd Men marke	Ĭ,	40161	1 lorie	40. 14.71		ALLIA	J (2)	BKIL	0.00
Maryland	12 sho h and 7 Is ma treum	-	19a, Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street and	Number or Rural F	foute Number, City	or Town, State, .	Zip Code)
	1 and Health em 27 thar tr		20a, Method of Disposition	20b. F	Place of Dispo	osition (Name of	Dat	9 20c, I	ocation - City or	Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28e-1 show any injury or othar treumetic avent, the Modical Examiner must be notified at ones.		1 Burial 2 Cremation 3 Control of	⊤i⊔euio∧si uotii ≥isie 2 ^6	cemetery, crei	matory or other place)	T LIGAT.	!!	A 11	Charles of
Ė	permit. Pages Department of Important: If i any injury or once.		21. Sign figre of Funeral Service Lice		175-T H	2. Name and Address	of Facility	H FO	5214	11 1 14 c 11 4 c 1
Ã	Departing Department of the services.		Man Hope	/	5	1800 HARE	140 KPE	O FORK	Pills 8	coelkara
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the deat	h. Do not ent		such as cardiac or r	espiratory arrest,		Approximate Interval Between
	Physician	(C.)	Immediate Cause (Final disease or condition	Metastroc	Pane	reatic (ancel			Onset and Death
П	/Medical		resulting in death)	Due to (or as a conseq	- +					
П	Examiner	L	Sequentially list conditions,	b						
	ed sit	nine	if any, leading to immediate Cause (Disease or injury	Due to (or as a conseq	juence or):					
1	axecur and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	(uence of):					
8760,	cate be executed physician and the burial-transit	dical	•	d. ======						
9	tificating phy as the	ledi				-				
Вох	death certific e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnancy			23d. Date of del	
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)			Month	Day Year
P.0	law requires that the as been signed by th 2 should be detache	Physician/Me	9 ☐ Unknown Part II. Other significant conditions		ushing in the s		in Danil	22a Did tahaasa	una cantributa te	the cause of death?
JS,	ires tha signed	l by	Part II. Other significant conditions	contributing to death but not res	uung ii iil o u	ndenying cause given i	III Fail I.	1 ☐ Yes 2	_	obably 4 Unknown
Ö	v requir	etec				_	-	24a. Was an		
Records,	o <u>c</u> o	Completed						autopsy performed?	prior to death?	itopsy findings available completion of cause of
a		e Co	25. Was case referred to medical				O Diana d Dank (1 Yes 2 N	o 1 ☐ Yes	2□ No
Vital	Phyaician: this certific ral director,	o B	examiner?	Hospital:	ER/Outpatier	Othor	 Place of Death (6 A Nursing Home 		6 VOther (Spe	intanivoice 1
10		\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			Describe how injut	- 1	W Copice
ion	Attanding death. ctor: Aft y the fun	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	on	Injury		s 2 □No			
Division	r Atta er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office	28f	Location (Street a City or Town, Stat		ıral Route Number,
	itel o									
	To the Hospitel or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edical	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina	owledge, deat ation and/or in	h occurred at the time, vestigation, in my opini	date and place, and ion, death occurred	due to the cause(s at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	thin 2 thin 2 the	Med	29b. Signature and title of certifier	and manner stated.		29c. License ni	umber	29d. Da	ate signed (Mont	h. Day, Year)
	8 1 8 1		Maria	Luns		0583			mber 6	
r	_		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type.	Print)				
	30		1 01	les no lobo		Charlesa	or Bulto	meen	x 2120x	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	/				
	Registr	ar	NOV 0 9 2	UU4 Janeara	B	Sports	/			

Muhr121-Boone, Lujean 11/6/04 @1025

			For State	State of Mar	yland / Depa	artment c	of Health an	nd Mental Hy	gien 2004	35380
			Registrar		Ce	rtificate	of Death		Reg. No.	
П	Physicia	an	Decedent's Name (First, Middle, Last PEGGY RUTH BRA					2. Date of De Month OCTOBE		3. Time of Death 5:00 A M
(10)	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Tov	vn, or Location of D		4c. County of Dear	
3.4	Se _t	4	RIVERVIEW CARE				SSEX		BALTIM	
	. Funeral Director		5. Social Security Number 6. S 216~28~0465	ex 7. Age (1	n yrs. last birthday) Yrs.	If Under 1 Y Months D		Min. 8. Date of Birt (Month, Da OCT 2	h y, Year) 9. Bird Cc 6, 1931 MAR	hplace (State or Foreign ountry) VI AND
	ס		Usual Residence of Decedent					001. 2	0, 1551 IIA	1
	// Aarylar	ō	MD. 10b. County		Oc. City, Town or Lo $ m BALT$:					10d. Inside City Limits 1 □ Yes 2 □ No
	r 28e-	Funeral Director	10e. Street and Number			10f. Zip Co	de		10g. Citizen of What Co	puntry?
	ath wit	ralD	4213 STANWOOD AVE				2120		U.S.A.	
	Items	nne	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent If Yes, specify	of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ame Black, Whit	
920	ours af	þ	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 🔀	No Specify:		Specify: W	HITE
5-0	"natu	letec	15. Decedent's E (Specify only highest gra		(Give	dent's Usual O kind of work d DO NOT use re	one during most of	f working	16b. Kind of Business	Industry
212	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Items 23c or 28e-f show sht, the Medicul Exarcic vernical be codified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ECRETAR	-		RAILROAD	1
Maryland 21215-0036	be filed ital Hyg id othe event,	Bec	17. Father's Name (First, Middle, Last)			· · · · · · ·		Name (First, Middle,	Maiden Sumame)	
<u> </u>	should ind Men s marke umatic	7	EDWARD ARNOLD 19a. Informant's Name/Relationship (Tyne Printl	19h Maili	na Address (Si		KNIGHT	ar, City or Town, State. 2	Zin Code)
	alth an 27 ls or trau		SUSAN CHURCH/SIST			-			IA, VIRGINI	100
Baltimore,	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28e-f show any in jury or other traumatic event, the Medical Examination traumatic event. The Medical Examination of the Incitities of the Inci		20a. Method of Disposition 1 □ Rurial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo LAKEVIEW	osition (Name of	rplace)	Date	20c. Location - City or	Town, State E, MARYLAND
Ē	it Pages rment of rtant: If it n ury or o	,	* 4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Liber	y)				10/21/04	. ZEILER &	- 15
Ba	Departiment Depart		DALL (Loyer					ORE, MARYLA	
			23a. Par 1. Inter the disease, or com short in heart failure. List only	plications that sused the	e death. Do not ent	ter the mode of	dying, such as car	rdiac or respiratory ar	rest.	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Houtin		SCH	ust ear			Onset and Death
	Examiner			Due to (or as a c	onsequence of):					
7	r	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c	onsequence of):					
1850	te be execut - 1 ysician and le burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):					"
760,		ical	(d						
x 68	The law requires that the death certificate to has been signed by the attending physbage 2 should be detached for use as the	/Med	IF FEMALE:	23c. If yes, outcome of	Droco and					. —
Вох	death c	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 (4 ☐ Pregnant at tin	Fetal death 3	Ectopic pregn Other (specif			23d. Date of del Month	Day Year
P.O.	at the d	hys	9 🗌 Unknown	9Ll Unknown						
	signed d be de	by	Part other significant conditions of	•	not resulting in the u	nderlying caus	e given in Part I.		obacco use contribute to ⁄es 2□No 3□Pr	othe cause of death? obably 4 [Uuknown]
Records,	s been si s should I	Completed						24a. Was	an 24b. Were au	itopsy findings available
l Re	(0	Som						— autop perfo 1 ☐ Yes	rmed? _ death?	completion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	Death (Check only o		
of		n; To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28b. Time o		Injury at Work?		dence 6 Other (Spectors)	cify)
sion	Attending r death. sctor: After	atio	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n	<i>(ear)</i> Injury	М	1 ☐ Yes 2 ☐ No			
Division	after d Direct in by	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		- At home, farm, str (Specify)	reet, factory, of	fice	28f. Location (S City or Tox	Street and Number or Ru m, State)	iral Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	SalC	29a. Certifier 1 Certifying Ph	nysician: To the best of r	ny knowledge, deat	h occurred at the	he time, date and p	place, and due to the	cause(s) and manner as	stated.
	the Hin 24 hin 24 the 54 mpletel	Medical	one)	niner: On the basis of ex and manner state	d.		cense number		gate and place, and due 29d. Date signed (Monti	
)	To To		29b. Signature and title of certifier Ticeael	CHAROUS			9667		LO -(9. 200	
•			30. Name and address of person who	completed cause of deal	th (Item 23a) (Type.			16.01		
	10		31. Date filed (Month, Day, Year)	completed cause of deal	Signature	ue they	. 208 (over Dome	es v emplore	
	Sta Registr		31. Date filed (Month, Day, Year)	2004 res	was to	9 hp	aks			

			1 - For State Registrar	State of Maryland	/ Department of Hea Certificate of De	ith and Mental F ath	lygier 12 Reg. No		35381
I	Physicia		1. Decedent's Name (First, Middle, Las FLIZABETH	1)	BUOTS	2. Date of Month	Death Da FMSER	y Year	3. Time of Death 12:48 A M
	/Medic Examin		4a. Facility Name (If not institution, give	A comment of the comm	4b. City, Town, or Loc	ation of Death	4c	. County of Death	1
	Funeral		North WEST (5. Social Security Number 6. Se	7. Age (In yrs. las		Jnder 24 Hrs. 8. Date of	Birth	BALTIM 9. Birth	place (State or Foreign
	Director	4	240-12-8001	□M 21√F 83	Yrs. Months Days He	ours Min. Month,	Day Year	Con	ntry) MD
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	the Mar	ector	Mb Baltim	rore l	PIKESVIII	e	10a Ci	tizen of What Cou	1 ☐ Yes 2 Q /No
	th with 23e or	Funeral Director	16 Old Court R	and and	212	2 08	log. Ci	1154	т.с. у :
	ter dea Items Inst. my	uner	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eyer in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yes or exican, Puerto Rican, etc.)	No-	14. Race - Ameri Black, White	
21215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show deal Examiner must be nutified at		3 Widowed 4 Doivorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Sp	pecify:		Specify: B	IACK
15-(iin 72 h n "natu Neolesi	Completed by	15. Decedent's Ed (Specify only highest grade)	de completed)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working		(ind of Business/Ir	
	filed within Hygiene. other then "		Elementary/Secondary (0-12)	College (1-4or(5+)	Inspector	2		lanyland	Glass
Maryland	ld be ental ked c	To Be	17. Father's Name (First, Middle, Last) ROV Stewart	-	18.	Mother's Name (First, Mid	die, Maider	n Sum a me)	LUNKNOWN
lary	2 shour and M Is mar	-	19a. Info ant's Name/Relationship (7	ype, Print)	19b. Mailing Address (Street and I	Number or Rural Route Nu	mber, City	or Town, State, Zi	9
	s 1 and f Health item 27 other t		20a. Method of Disposition	-	ce of Disposition (Name of netery, crematory or other place)	Date	20c. L	ocation - City or T	2 2136 own, State
Baltimore,	permit. Pages Department of Important: If it is eny injury or conce.		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Janey Valley	11-12-04	Tin	nonium	am.
Ball	permit Depart Import eny in		21. Signature of Funeral Service Licen	J/	22. Ume and Addr & f	Facility Gughn C			enal Srics. NO 21133
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death.	Do not enter the mode of dying, su			101111	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		ARTORY	PISEASE	=		Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a conseque	rice or):				
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (pusease or injury	Due to (or as a conseque	nce of):				
o,	ficate be executed g physicien and is the burial-transit		that initiated events resulting in death) Last	Due to (or as a conseque	nce of):				
68760,		edical		d.					
Вох	es that the death certifigned by the attending be detached for use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 Live birth 2 ☐ Fetal d	eath 3 ☐ Ectopic pregnancy			23d. Date of deliv	very Day Year
P.O. E	the dea y the al	Physiclan/M	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	th 5 ☐ Other (specify)			WORK	Day Tour
	The law requires that the death certive has been signed by the attending bage 2 should be detached for use a	ρχ	Part II. Other significant conditions of						the cause of death?
cord	w require been si should l	leted	(ONGESTIVE)	HEART (-ALCO	<i>(Le</i>	24a. W		T-100-00-0	opsy findings available
of Vital Records,	The lay	Completed				a p	utopsy erformed? is 2 2/No	prior to co death?	ompletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othor	Place of Death (Check on			
Jo L	ding Physician: h. After this certific funeral director,	on: To	1 Yes 2 No 27. Manner of Death	1	R/Outpatient 3 DOA 28c. Injury at Work?	Nursing Home 5 R			fy)
Division	ten feat for: the	icatic	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes		in (Straat ar	nd Number or Run	ral Poute Number
<u>≥</u>	s after set in by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	e, rami, sheet, ractory, onice		Town, State		ai rioble ivaliber,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one)	ysician: To the best of my knowl iner: On the basis of examinatio and manner stated.	edge, death occurred at the time, den and/or investigation, in my opinion	ate and place, and due to to n, death occurred at the tir	the cause(s) and manner as s d place, and due t	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier		29c. License nur	nber		te signed (Month,	
į		6	30. Name and address of person who	M D	P 5 7 7 2			EMBER	7 2004
4)(,		LEGNARD RICHARDS	70N >4010LD	COURT ROAD RI	ANDALLSTOWN	MD	21133	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2004	32. Registrar's Smatu	sports'				

			1 - State of Maryland / Depa	artment of Health and Mental Hygie tificate of Death	
	Physici /Medio		1. Decedent's Name (First, Middle, Last) TOYCE LYNN CARNEAL	2. Date of Death Month	Day 5 Year 0805 Am
B	Examin		4a. Facility Name (If not institution, give street and number) North Arundel Hospital	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 212-70-3802 6. Sex 1 M 2X F 50 Yrs. last birthday)	Months Days Hours Min. Feb 5, 15	9. Birthplace (State or Foreign Country) Mary Land
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel Pasadena		10d. Inside City Limits 1 □ Yes 2X No
	with the Jaor 28a-	Direc	1082 Woodlawn Avenue	The second secon	Citizen of What Country?
36	s after death ; or items 2	by Funeral	1 Nover Married 2 Married 1 Tyes 2 M No	Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural; or items 23e or 28e-f show amy injury or other traumatic event, The Medical Exactli at Irinal ke notified at Once.	Completed b	15. Decedent's Education (Specify only highest grade completed) (Give (life, Life, nd of work done during most of working DO NOT use retired)	b. Kind of Business/Industry	
and 21	ould be filed wi Mental Hygien Parked other th	To Be Cor	12 4 Pna 17. Father's Name (First, Middle, Last) Edward Yanke	rmacy Technician S 18. Mother's Name (First, Middle, Mail Thelma Sanders	afeway Food & Drug
	nd 2 shoul Ith and Me 27 is mark	ř		ng Address (Street and Number or Rural Route Number, C. Woodlawn Ave., Pasadena,	
Baltimore,	Pages 1 all ment of Hea ent: If item ury or othe		20a. Method of Disposition 1 Burial 2 Commation 3 Removal from State 4 Donation 5 Other (Specify)	rematory, Inc. 11/10/04 B	c. Location - City or Town, State altimore, Maryland
Batt	permit. Depart import any inj		3	Name and Address of Facility CCully-Polyniak Funeral Ho 204 Mountain Kd., Pasadena	· Ma·
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner	er	Due to (or as a consequence of): Sequentially list conditions b.		
,	icate be executed physician and s the buriat-transit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
68760,	rtiticate br ng physic s as the br	Medical	d		
.O. Box	that the death certitic ed by the attending p detached tor use as	by Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
٥.	The law requires that the ate has been signed by th page 2 should be detache	ted by Pt	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Did tobac	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,		Completed			24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 1 No
on of Vit	Phys this al di	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident 1 Accident 1 Inpatient 2 FR/Outpatien 28a. Date of Injury (Month, Day Year) Injury		
Division	el or Atter s atter dea il Director id in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	eet, factory, office 28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely tilled in by the funer	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one)		
į	Vithi Tot comp	Σ	29b. Signature and title of certifier 1. Crosson Officery, mg	29c. License number 29d. No.	Date signed (Month, Day, Year) V. 5, 2 oc 4
(4		30. Name and address of person who completed cause of death (Item 23a) (Type, T.CEDSSAN O DONO VAN, Mb 211) mb 21222
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 9 2004 32. Registrar's Signature	Sporks	

State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registra 35383 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 Month Dorothy Elizabeth Christman **Physician** 3:35 P M Nov. 6, /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Glen Burnie 1591 Dulaney Lane Anne Arundel If Under 1 Year | If Under 24 Hrs. Birtholece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Days Hours Min 1 ☐ M 2 🖾 F 82 Yrs. 214-12-2106 Director 1922 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🗑 No Glen Burnie Maryland Anne Arundel Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1591 Dulaney Lane 21060 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Associated Printer Wrapper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Poteet Mary Elizabeth Hodges ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol White 1591 Dulaney Lane, Glen Burnie, Md. (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem. Pk. 11/10/2004 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home, P.A. 237 F. Patapsco Ave., Balto., Md. Kevin E Ecker 21 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interva B. tween Onset Death ADENOCARCINOMA Immediate Cause (Final month **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed as the burial-transil the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) detached 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perrormed? 1 ☐ Yes 20 No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes A No Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident after death filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a To the Funeral D 1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Days signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type 028 MO 32. Registrar's Signature State Registrar

Unperiod Tem#23a, 27, perMI, G838, 12/18/04 TI

	1	For State Registrar		17 Department of F Certificate of	Death	Reg.	2004	35381
Physician /Medical		1. Decedent's Name (First, Middle, Last DANE ED) WARD CLARK			2. Date of Death Month NOVEMBER	7, 2004 ar	3. Time of Death 10:50 P
Examine	r	4a. Facility Name (If not institution, give MD HOUSE OF CORRE		4b. City, Town, of JESSU	or Location of Death JP		4c. County of Death ANNE A	RUNDEL CO
Funeral Director		unknw.	7. Age (<i>In yrs. la.</i> M 2 F 54	st birthday) If Under 1 Year Months Days	1 1	8. Date of Birth (Month, Day, You October	9. Birth 241950 Vi	place (State or Fore ntry) Sginia
show	-	Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Lim
vith the Mar	9010	Maryland Anne Aru	ndel	Pasadena				1 🗌 Yes 2 👿
Sa or 2		10e. Street and Number 6 Appian Way		10f. Zip Code	122	10g.	. Citizen of What Cou	ntry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene and the file of items 23a or 28a-1 show both, the Marified Examiner out the routified at the foundated by Eurada Director.	by runera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			cify Yes or No- Rican, etc.)	U.S.A. 14. Race - Ameri Black, White	etc.
ed within 72 hou ygisne. ner than "natura" t, the Missiral E.		15. Decedent's Edu (Specify only highest grad	ication	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	168	b. Kind of Business/Ir	ndustry
e filed with Il Hygiene. other ther vent, Ille N		12 17. Father's Name (First, Middle, Last)	0	Electric	ian 18. Mother's Name	/First Middle Mai	Self-Empl	oyed
e d la la	one	Guy J.	Clark				gate	
C (G 80 5		19a. Informant's Name/Relationship (T)		19b. Mailing Address (Street		Route Number, C	ity or Town, State, Zi	Code)
1 and lealth im 27 har ti		Lou Ann Clark 20a. Method of Disposition	(Mother)	6 Appian Way			and 21122 c. Location - City or T	Our State
Pages nent of P int: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☑ Donation 5 ☐ Other (Specify)	Removal from State Cer	netery, crematory or other place 1fonte Mem. Gd	ce)	-	ıssell,Ken	
permit. Pages. Department of I Importent: If ite any injury or of once.		21. Signature of Funeral Service Ligens		22. Name and Addre McCully-Po 3204 Mount	ss of Facility			
Physician / Medical Examiner the burial-transit full full full full full full full ful		disease or condition resulting in death) Seque Hally list not differ the death of	b. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	ence of):	ac Cardiov	vascular	Disease	
To the Hospitel or Attending Physicien: The taw requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	nysician/medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	leath 3 Ectopic pregnancy	,		23d. Date of deliv Month	ery Day Year
quires than a signed ald be de	ò	Part II. Other significant conditions co	ntributing to death but not result	ing in the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	
: The taw requii						24a. Was an autopsy performed	prior to co death?	opsy findings availa mpletion of cause 2 No
s certification	2	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3☐ DOA Oth	26. Place of Death	(Check only one)	, Consider Consider	COTT VE
nding Phy tth. : After this e funeral d	- (b)	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation		28c. Injury Wor	v at 28	Bd. Describe how i	1-1-1	9 SCENE
tel or Attending P rs after death. al Director: After ted in by the funeraction of the funeraction.	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Ruri itate)	al Route Number,
the Hospi in 24 hou the Funer pletely fill	alical		sician: To the best of my knowledge: On the basis of examination and manner stated.					
ithin the composite of	ME	29b. Signature and title of certifier	1010	29c. Licens	e number M E		Date signed (Month, VEMBER 8,	
F 3 F 8		latine	las T	- 0	11 1	110	VIIIDIIN O,	2004

			For Stete Registrar		State of M	Maryland /	Depa Cer	artment of F	lealth a	and Mer		giene Reg. No.	2004	35385
			Decedent's Name (First, Management)	/liddle, Las	t)					2.	Date of De	ath	V	3. Time of Death
	Physici		Doris			$C_{\mathcal{C}}$	ou:	5.0		n	Month	Day		44:24 PM
	/Medic Examin		4a. Facility Name (If not insti	tution, give	street and number			4b. City, Town, o	r Location	of Death		4c.	County of Dea	th
			200010- 1	s Bay		edial a	Nes	Balt.	nor.					
	Funeral		5. Social Security Number	6. \$6	ox 7 □M 2 /CX F	Age (In yrs. last 64	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Birt (Month, Da		_ C	thplace (State or Foreign puntry)
	Director		225-54-0075 Usual Residence of Deceder			04	113.			000	tober	9,1	940	VA.
	/land		10a. State 10b. Co			10c. City, To	own or Lo	cation						10d. Inside City Limits
	Mar.	tor	MD. Bal	timore		I	Dunda	ılk						1 ☐ Yes 2 🛣 No
	d within 72 hours after death with the Maryland jiene. r than "neturel", or Hems 23e or 28e-f show the Marical Ezatrativa i wat be invitited at	i Director	10e. Street and Number 7302 Dunwall	Court	Apt A			10f. Zip Code 21	222			10g. Citi	zen of What Co U	ountry? SA
	death	Funeral	11. Marital Status		12. Was Decede Armed Force		13.	Was Decedent of H	lispanic Ori	igin? (Specify	Yes or No	-	14. Race - Ame Black, Whit	
98	or Ite	y Fu	1 Never Married 2		1 ☐ Yes 2 [If Yes, Give	χνο		1 ☐ Yes 2 ဩ No	Specify:		, 5.0.,			hite
21215-0036	hours lurel',	ed by	3 XWidowed 4 □ Divo	edent's Ed	Year or Date		Sa Dece	dent's Usual Occup	ation			16h Kii	nd of Business	
1 5	in 72	Completed	(Specify only t	ighest grad	de completed)		(Give	kind of work done DO NOT use retire	during mos	it of working		100. Kii	10 01 00311033	andustry
212	filed within Hygiene. ther than " int, the Mas	mo	Elementary/Secondary (0- 5 vears	12)	College (1-4d	or 5+)	Ho	ousewife				C	om Home	е
	it,	BeC	17. Father's Name (First, Mic	ddle, Last)						er's Name (F		Maiden	Sumame)	
/lar		To E	Harry Craft						I	Lena Be	ess			
Maryland			19a. Informant's Name/Rela	tionship (7	урө, Print)			ng Address (Street				-		Zip Code)
	5 = 0 -		Janet Bruner		laughter			 Dundalk sition (Name of 	. Aver				cation - City or	Town State
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Crema			te ceme	itery, crer	natory or other pla		Novemb				
ij	permit. Pages Department of Importent: If i eny injury or o		`4 ☐Donation 5 ☐ Oth 21. Signature of Funer# Se			Uak .		Cemetery		9, 200			dalk,MD	
Ba	permit. F Departm Importer eny injui		htho	111-	(000	00 /1		Name and Address Onnelly F 110 Solle	unera	il Home	of I	ounda Sunda	alk,P.A	21222
			23a. Part1. Enter the diseas	e or comp	olications that caus	sed the death.							iin,ria.	Approximate Interval Between
	Pnysician		shock, or heart failure. Immediate Cause (Final	trist only o	one cause on each	//			Sait					Onset and Death
	/Medical		disease or condition resulting in death)		a. Due to Fr	as a consequen		alaron.	a					sweeks
	Examiner		Sequentially list conditions,	- 1	b. Sen	ero co	hron.	= 05st	wet:	E Du	lmona	, 1	50000	10 years
	pe tisi	iner	cause. Enter Underlying	1	Due to (or	as a cons → ueno	ce of):	a obsti	_		,	,		1-
	ate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c. Due to (or	as a consequence	of):	hyper T	ers.	On				10 years
8760,	be exician					,	7	7 *						
687	ficate physis the	edicai			d									
Box (eath certific attending p I for use as	N/A	IF FEMALE: 23b. Was decedent pregnar	nt	23c. If yes, outcor			T-+i				2	3d. Date of de	livery
	death e atte	icia	in the past 12 months? 1 □ Yes 2 🗷 No		4☐ Pregnant	2 Fetal death at time of death		Ectopic pregnancy Other (specify)	y 				Month	Day Year
P.O	at the de by the tached	Physician/M	9 □ Unknowň		9□ Unknowr					-				
	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	by	Part II. Other significant co		_		- ,		1	-		,		the cause of death?
ord	w require been si should t	ted	Circhus:	5	right -	s.ded	ne	est ta	/we		X		□No 3□Pr	robably 4 Dunknown
Records,	e law has b je 2 st	Completed									24a. Was autop		24b. Were at prior to death?	utopsy findings available completion of cause of
a E											Yes	2 🗆 No	1 🗆 Yes	2 X No
Vital	sician: certific irector,	o Be	25. Was case referred to me examiner? 1 ☐ Yes 2XNo	-	Hospital:	tiont OFF	Outpatien	t all post Oth	.05	e of Death (C			☐Other (Spe	a.if.d
of	Phys or this oral di	H	1 ☐ Yes 2 No 27. Manner of Death	12.2	28a. Date of I	njury 281	o. Time of	28c, Injur	ry at		Describe h			City)
ion	Attending death. ctor: Afte y the fune	ation		ending vestigation		Day Year)	Injury	Wor M 1 □	nk? Yes 2.□	No				
Division	or Attending F after death. I Director: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ C	ould not be stermined	289. Place of	Injury - At home, etc. (Specify)	, farm, str	eet, factory, office		28f.	Location (S City or Tox	Street and	d Number or Ru	ural Route Number,
	tel or A	Cer			Name of the state									
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical			y sician : To the be niner: On the basis and manner	of examination								
	within To th comp	Me	29b. Signature and title of co					29c. Licens					signed (Mont	
)			16/12	-	MD 1	PhD		Re	3-0	000	/	Vova	mber 6	, 2004
\	į		30. Name and address of pe	rson who	completed cause of	of death (Item 23	а) (Туре,	Print)	-					
	<u> </u>		Dr. Mic	hae!	trock	es 49	140	Caster	Ave	nue,	Bal	1 in	re, M	(, 2004 1) 2/224
	Sta Registi		31. Date filed (Month, Day,	1 9 20	104 32. Regi	strars Signature	5	Spark	2					•
	riegisti		HOA	A A PP	101		/	//						

	•	For State Registrar	State of	Marylan		artment of H		Mental Hyg	iene () () L	35386
		Decedent's Name (First, Middle,	Last)					2. Date of Deat	th	3. Time of Death
Physicia		Dorothy Myrt1	e Costin					Novembe	er 5, 200	
/Medic Examine	_	4a. Facility Name (If not institution,		ber)		4b. City, Town, or	Location of De	ath	4c. County of De	
CAUTITIO	-	Eastpoint Nursi	ng and Rei	habilit	ation	Baltimo:	re		Balt	imore
Funeral			5. Sex 7	. Age (In yrs.		If Under 1 Year	If Under 24 H		0.0	irthplace (State or Foreign Country)
Director		219-16-6283	1 □ M 2 ØF	82	Yrs.	Months Days	Hours M	8/30/1	922	MD
2		Usual Residence of Decedent		10- 01-						Teal to the action
arylar show	_	10a. State 10b. County	. •	Toc. City	y, Town or Lo		ъ.			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
88 -1:	cto		timore				vs Poin			
or 2	Director	10e. Street and Number	1 D 1			10f. Zip Code	01010	1	0g. Citizen of What (ŕ
UU36 hours after death with the Maryland tural; or items 23s or 28s-1 show at Exemples invest be invitited at		4552 Sandwoo		T			21219	(2)		SA
er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Ford	ces?	5. 13.	Mas Decedent of Hi f Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, Wh	nerican Indian, lite, etc.
rs aft	by	3 X Widowed 4 Divorced	If Yes, Give	•		1 ☐ Yes 2 📉 No	Specify:		Specify:	White
thou attern	be	15. Decedent's			16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busines	s/industry
d 21215- filed within 72 Hygiene. other then "nel ent, the Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	Aor E I \	(Give	kind of work done o DO NOT use retired	during most of v l)	vorking		
filed with Hygiene. other therent, men.	E	6	College (1-	401 34)		Homemake	er		Own	Home
ING 21215-0036 be tiled within 72 hours after death with the Marylar ital Hygiene. Id other than "natural", or itams 23a or 28a-1 show event, the Medical Eventiner must be notified at	Bec	17. Father's Name (First, Middle, L.	ast)				18. Mother's N	lame (First, Middle, I	Maiden Sumame)	
	To	William Ely					Vio:	let May Lu	thardt	
Maryland 21215-0036 d 2 should be filed within 72 hours al th and Mental Hygiene. 7 is merked other then "natural", or traumatic event, the Medical Even		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street a	and Number or	Rural Route Number	City or Town, State	Zip Code)
re, Maryle s 1 and 2 should f Health and Mer titem 27 is marks other traumatic		Linda Hoffman	/ daughte				ood Road	d, Sparro	ws Point,	MD 21219
or He		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 Removal from S		lace of Dispo emetery, crei	sition (Name of natory or other plac	θ)	Date	20c. Location - City	or Town, State
Pages nent of nent; If it		'4 □ Donation 5 □ Other (Sp.			yland	Veterans	Cem 1	1/9/2004	Crownsvi	lle, Maryland
Baltimore, permit. Pages 1 an Department of Heal important: If item 2 any injury or other once.		21. Signature of Funeral Service L	censee	. / M.	0/357	. Name and Addres		-		Home, P.A. ie, MD 21061
1		23a. Part1. Enter the disease, or o	omplications that ca	used the death						Approximate Interval Between
Pnysician		shock, or hear failure. List of immediate Cause (Final)	nly one cause on ea	ICH line.	2-511	DERN	5 NI) CANO	8	Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (c	or as a consequ	uence of):	12/5/	NA E	of CPIRC	C.	1
Examiner			ATX	IAL	L	22/11	AT10	N		
ET 20	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequ	uence of):		_		_	-
outed Tansii	Examiner	that initiated events	· CoRc	NA	24 /	HATE,	RY_I)15EA52	Ž	
O, e exe an ar arrial-t	EX	resulting in death) Last	Due to (d	or as a consequ	vence of):					
18760, Cate be executed physician and sthe burial-transit	dlcal	(1)	d							
ntifica	0	IF FEMALE:								
Hecords, P.O. Box 68760, The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outc	come of pregnanth 2 Feta		Ectopic pregnancy			23d. Date of d Month	elivery Day Year
O. E	SICI	1 Yes 2 No	4□Pregna 9□Unkno	int at time of di wn	eath 5	Other (specify)			N.G.	Day Toal
that the de detached is	Ph	Part II. Other significant condition	e contributing to do	ath hut agt can	ultina ia tha	adarkijas asusa suu	on in Doubl	220 Did tol	aaaa usa saatsibuta	to the cause of death?
S, Fres that igned be del	þ	Part II. Other significant condition	is contributing to de	ain bui noi resi	uiting in the u	nderlying cause give	en in Pan I.			Probably 4 Dunknown
Records, he law requires t has been signe ge 2 should be	ted								3S 2 NO 3 N	-Tobably 4 Dankilowii
law law las b	Completed							24a. Was a autops	n 24b. Were	autopsy findings available completion of cause of
The The page	So							perform 1 Yes 2	ned? death? 2	
Vital Rec sician: The law s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Unanitali			104		eath (Check only on	θ)	
hysi hysi at dir	2	1 ☐ Yes 2 ☑ No			ER/Outpatier	-	4 X Nursing	Home 5 Reside		ecify)
ing F	inol.	27. Mann Death 1 Latural 5 Pending		f Injury n, Day Year)	28b. Time o Injury	Work	ς?	28d. Describe ho	ow injury occurred	
ISIO	cat	2 Accident investigation inves	ot he	of Indiana . As he			Yes 2 □ No	296 Looption (C)	and and Alumbas and	Description of the second
DIVISION OF I or Attending Physalter death. Diractor; Atter this Jin by the funeral d	Certification:	4 Homicide determin	buildin	g, etc. (Specify	y)	eet, factory, office		City or Town	reet and Number or I n, State)	nurar noute rumber,
pital purs a ours a filled		29a. Certifier Certifying	Physician: To the	hast of my kno	wledge deat	a accurred at the tim	no, date and pla	ace, and due to the ca	auco/s) and manage	
24 hc Fun stely 1	Medical	(Check only 2 Medical E	xaminer: On the ba and mann	sis of examina	tion and/or in	vestigation, in my of	pinion, death oc	courred at the time, d	ate and place, and d	ue to the cause(s)
DIVISION Of VITAL HO To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier				29c. License	number	2	9d. Date signed (Moi	nth, Day, Year)
F S F 0		Vairado 1	1/51-11	/ 10	3	カラ	2/8	3	Wak	4
		30 Name and address of person w	no complete o casse	of death (Item	23a) (Type.	Print)	, "			
η		Sarvagas 1	161.11	2	MA	Stat	XICACI	e SIA	MAKE C	1 2/222
Sta	te	31. Date filed (Morth, Day, Year)	32. Re	gistrar's Signa	ture		100	1/4	- 4 4	-
Registr		NOV 0 9 20	114 Sel	مصمم	9	Sparker				

State of Maryland / Department of Health and Mental Hygiene 2004 35387 For Per FH C899 Prifice 1905 Grath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0250 AM elen November 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LANOR KISING If Under 1 Year | Under 24 Hrs. Wonths Days Hours Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

MAKYLANA Date of Birth (Month, Day, Year) **Funeral** Sex 1□M 2DF Months 218-36-920 Yrs. Director Usual Residence of Deceden with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Examiner must be notified at BALTIMORE 1 10 10 200 No MD Director BALTIMORE PERRY HALL 10e. Street and Number B BROOK FARM CT 10g. Citizen of What Country? USA "natural", or itams 23a Completed by Funeral aven 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or iter 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white. 3 Widowed 4 □ Divorced event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 2 IERCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) at of Heate, it: If Hem 27 is ON 4000 Field 20b. Place of Disposition (Name of TR-SON Hall relag Date Oc. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny injury or once. akoview Mem Gardens 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Timoplium, mo Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each sup. Immediate Cause (Final disease or condition resulting in death) ENILE **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medicai the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe HYPERTENSION 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed DIABETES MELLINS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☒ No 24a. Was an page 2 s autopsy performed certificate 1 Yes 28 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ို 1 Yes 2K No 1 Inpatient 3□ DOA 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation Natural death. 1 TYes 2 🗌 No 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the I 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H58419 November 4 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO 1881 TELEGISAPH DONHAM KANGOY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Donna 04-7 AKG

Please Type or Print in Black Indelible Ink Engure All Co

a Carman 187		Amendi	tem#23a,2 State	27, 28a-t	perME	G835	, 17 1	3/05	and M	lental Hy	Are	Legible.	05000
107		1 - For State Registrar	Olalo	or wary ar	Cei	tificat	e of L	Death	AIIG IV		Reg. No		35388
		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath		3. Time of Death
Physici /Medic		Donna Faye Ca	rman							Month Novemb	Da er (6, 2004	3:05 P M
Examir		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City,	Town, or	Location of	of Death		4c	. County of Deat	h
		236 Bishop Gler		7 4 //	to a bitable to a	Fred If Under	deric	ck If Under	O.4 Hen			Frederi	
Funeral Director		5. Social Security Number 213–84–3443	6. Sex 1 ☐ M 2 ☐ AF	7. Age (In yrs. 42	Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Day Sept.	h Y. Year)	9. Birti	hplace (State or Foreign untry) ryland
D		Usual Residence of Decedent								Sopo.		1702 110	1 y Land
arylan show		10a. State 10b. County		10c. Cit	ty, Town or Lo								10d. Inside City Limits
88a-f	ecto		lerick		Frede								1 ☐ Yes 2 🗗 No
with t	Dir	10e. Street and Number	nn Duise			10f. Zip					10g. Cit	tizen of What Co	untry?
seath ns 23	Funeral Director	236 Bishop Gle		edent Ever in U	l.S. 13. 1	Was Deced	2170 ent of His		ain? (Spe	ocify Yes or No-	.	U.S.A. 14. Race - Ame	ncan Indian
or Iter	Fun	1 Never Married 2 Marri	ed 1 TYes	edent Ever in U orces? 2 🐴 No					, Puèrto	ecify Yes or No- Rican, etc.)		Black, White	
ours a	d by	3 ☐ Widowed 4 🌪 Divorced	If Yes, G Year or I	ove Dates:		1□Yes 2	ZIAJ No	Specify:				Specify: Wh	ite
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It Is marked other than "natural", or Items 23e or 28e-f show traumetic event, the Modical Ever it with a tast be tradified at	Completed	15. Decedent (Specify only highes		1	16a. Deced	kind of wor	k done d	uring mos	t of worki	ng	16b. K	(ind of Business/	ndustry
withir ene.	dmo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Bak	oo notus er	ө гөшгөа)					Candy S	hop
filled Hygi other ant, I	Be Co	17. Father's Name (First, Middle,	Last)					18. Mothe	or's Name	(First, Middle,	Maiden		
yland 2 ould be filed v Mental Hygie tarked other i	To B	Howard Beyer	ly Caltr:	ider				Ca	ther	ine Fay	e Sr	pencer	
Taryla 2 should and Men Is marke		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	er or Rura	l Route Numbe	r, City o	or Town, State, Z	ip Code)
		Catherine Faye	Rosier -		140_	Wenga	te F	ld. O				a. 21117	
Baltimore, Dermit. Pages 1 ar Department of Hea Important: If item; any injury or other one.		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation		State Days	Place of Dispo	natory or of	her place)		ate		ocation - City or	
Baltimord permit. Pages ' Department of H Important: If its any injury or of		 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service I 		Dru	uid Rid	. Name an		1		JO4	Pı	kesvill	e, Md.
Department and and and and and and and and and and		I Six Es	1200							agel P.	Α.		Md. 21117
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory an	ngs rest,	MILLS,	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition		nadone I									Onset and Death
/Medical		resulting in death)		(or as a conseq		acioi	I						
Examiner	L	Sequentially list conditions,	b										
led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as a conseq	uence ot):								
60, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):				-				
0 5 0	cail		d										
Box 68 leath certificat attending phy	edi	IE EENAN E.	T										
BOX 68 death certifica e attending ph	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregna birth 2 ☐ Feta		Ectopic pre	gnancy					23d. Date of delive	,
. 0 000	Physician/M	1 Yes 2 No	4☐ Pregi 9☐ Unkr	nant at time of d lown	eath 5□	Other (spe	ecify)					MONTH	Day Year
ਰ ਸ਼ੂਬ ਜ਼ਿਲ੍ਹੇ ਸ਼ਿਲ੍ਹੇ	/ Ph	Part II. Other significant conditio	ns contributing to c	leath but not res	ulting in the ur	derlying ca	use give	n in Part I.		23e. Did to	bacco u	use contribute to	the cause of death?
dS, luires n sign lid be	d by									1 🗆 Y	es 21	□No 3□Pro	babiy 4 □Unknown
COLD tw require s been sign should b	ojete									24a. Was a	ın	24b. Were aut	opsy findings available
VItal Kecords, siclen: The law requires to certificate has been signe rector, page 2 should be or	Completed					•				autops perform		prior to co	ompletion of cause of 2 No
	Be C	25. Was case referred to medical examiner?						26. Place	of Death	Check onl or		X = 100	20,10
Of V Physic r this corral dire	၉	1 ∑ Xes 2 □ No	The second secon	Inpatient 2			A Other	4 Nu	rsing Hon	ne 5 Reside	ence (6 Other (Speci	(y) at scene
on o	ion	27. Manner of Death 1 Natural 5 Pending		W	28b. Time of Injury	28 M	Work	at		8d. Describe h	ow injur	y occurred	
DIVISION for Attending after death. Director: After tin by the fune	ficat	2 Accident investig 3 Suicide 6 Could n	LL/O	/2004 of Injury - At ho	2:00 pme, farm, stre			مع دليمي	1.EI	nk . 18f. Location <i>(S</i> .	treet an	d Number or Ru	al Route Number
DIV all or A safter I Dirac	Certification:	4 Homicide		e of Injury - At ho ing, etc. <i>(Specif</i> ad at re					1	City or Town Frederi	n, State Ck	236 Bis Marylan	al Route Number, hop Glenn d
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certific: completely illed in by the funeral director.		29a. Certifier 1 Certifyin	Physician: To the	e best of my kno	wledge, death	occurred a	t the time	a, date and	d place, a	nd due to the c	ause(s)	and manner as	stated
To tha H within 24 To tha F complete	Medical	oney	xaminer: On the band man	iner stated.					n occurre				
To With	2	29b. Signature and title of certifier	1 20 10	21	e-	29c.	License					e signed (Month,	
,		Calu	uece	>//	7.	2-1-4	O.C	.M.E.			Nov	ember 7,	2004
		Zabiullah Ali,		se of death (Item	n 23a) (Type, I		Penn	Stre	æt,	Baltimo	re,	Marylar	nd 21201
Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's Signa							•		
Registr	aŗ	NOV	9 2004	Blown	K.	Good	U						
DHMH 17 Rev 1/2	001			(8, 1	- 1								

		1	For Stata Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of F	lealth and Death		Reg. No.	004	35389
	Physicia	an	Decedent's Name (First, Middle, Last) Scott Dav	id Davis				2. Date of Dea Month Novembe	Day	Year 2004	3. Time of Death 11:45am ^M
	/Medic Examin	_	4a. Facility Name (If not institution, give s Carroll Hospital			4b. City, Town, o Westmi		ath		ounty of Death 1rroll	
Ī	Funeral Director		5. Social Security Number 6. Sex 215-62-3190	M 2□F 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		h y, _{Yeer)} , 196	9. Birthp Coun MD	place (State or Foreign ntry)
	Aaryland f show	50	Usual Residence of Decedent 10a. State 10b. County MD Carro1	,	, Town or Lo	ocation csburg				1	0d. Inside City Limits 1 ☐ Yes 2 🛣No
	ier death with the Marylar items 23a or 28a-f show iter must be notified at	Director	10e, Street and Number 3150 Wheatfield R	nad		10f. Zip Code	048			n of What Cour	itry?
36	within 72 hours atter death with the Maryland ene. Than "natural", or liams 23a or 28a-f show ha Medicul Evana er must be notified at	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:				(Specify Yes or No erto Rican, etc.)	- 14.	. Race - Americ Black, White,	
Maryland 21215-0036	within 72 hours afte ene. than *natural', or i he Medicul Eval.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation o completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Physicia	during most of v d)			of Business/Inc	
land 2	hould be filed withind Mental Hygiene. marked othar than matic evant, the Mental Hygiene.	To Be Co	17. Father's Name (First, Middle, Last) Harvey Davi	S			18. Mother's N	dame (First, Middle, dine Mos		ımame)	
	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (Type Mrs. Mary P. Davi			•		Rural Route Numbe Finksbur			(Code)
Baltimore,	Se do		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. P	lace of Dispo emetery, crea	osition (Name of matory or other pla cy Cremat	Srv.	Date /10/04		ition · City or To ${ m sville}$,	
Balti	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service License			ATGHT FU	NERAL"H	OME & CHA 21784 (41	PEL,	PA (Box	: 195)
	Pnysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death le cause on each line.	n. Do not en	ter the mode of dyi	ng, such as card	liac or respiratory a	rest,		Approximate Interval Between Onset and Death INUTES
	/Medical Examiner	Jer	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underrying	Due to (or as a consequence of the consequence of t			,	·			
(1.09Z)	ite be executed lysician and ne burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnanc □ Other (specify)	у		230	d. Date of delive Month	ery Day Year
	uires that n signed b id be deta	Þ	Part II. Other significant conditions con Sevena Psom	atributing to death but not res	ulting in the u	inderlying cause gr	ven in Part I.		obaccouse Yes 2152∰	4	he cause of death? pably 4 Unknown
Records,	The law requir te has been si bage 2 should	Completed	Chronic Del	oilitated (Cond	ition		24a. Was auto perfo	an 2 osy rmed? 2 2 No	prior to con death?	opsy findings available impletion of cause of
Vital	sician: s certific lirector,	To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Ot		Death (Check only of		□Other (Specif	(v)
ō	ding Ph n. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju		28d. Describe			
Division	To the Hospitei or Attendi within 24 hours after death. To the Funeral Diractor; A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (. City or To	Street and I wn, State)	Vumber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical (29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exemi	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the tinvestigation, in my	me, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) ar date and pi	nd manner as si lace, and due to	tated. o the cause(s)
Ł	To the To the comp	Σ	29b. Signature and title of Contifier	0		DDC	36117			3-04	Day, Year)
	6+1		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type	Print) Nov.	thwoo	ds Train	14	ampsto	2074 MD 21074
	Sta Regist		31. Date filed (North, Day, Year)	32 Registrar's Signa	ature	Sports					

			1 - For State Registrar		flaryland / De	part	tment	of H					2004	
	Physici /Medi		1. Decedent's Name (First, Middle, Las Eleanor Drennon	st)							2. Date of Do Month November		^{ay} 2004 ^{Year}	3. Time of Death 5:30 P M
	Examir		4a. Fecility Name (If not institution, give 1211 Fourth Rd.	street and numbe	7)	4			Location of Rive:				County of Dea	
	Funeral Director		5. Social Security Number 6. S 237–26–8626	ex 7.7 □M 2⊠F	Age (In yrs. last birtho 90 Yrs	N	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Bi (Month, D Feb. 1,	rth ay, Year) 1914	9. Bi Pen	rthptece (Stete or Foreign Country) NSVlvania
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Loont	line							
	72 hours after death with the Maryland "naturel", or Itame 23a or 28a-f show calcal Examiner mark be multibut at	ctor	Maryland Baltimor	re	Middle									10d. Inside City Limits 1 ☐ Yes 2 No
	or 2	Dire	10e. Street and Number				10f. Zip (_	tizen of What C	ountry?
	23e	ra	1211 Fourth Rd.					1220					SA	
	er de	une	11. Marital Status	12. Was Deceder Armed Force:	nt Ever in U.S.	3. Was	s Decede es, specif	nt of Hi y Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh	
0036	urel', or	Completed by Funeral Director	1 Never Married 2 Married	1 ☐ Yes. 2(If Yes, Give Year or Dates	:		Yes 2		Specify:				Specity: W	hite
Baltimore, Maryland 21215-0036	C * 38	nplete	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) Cotlege (1-40	r 5+)	ive kind e. DO	NOTuse	done a	uring most	t of workii	ng	16b. K	(ind of Busines:	s/Industry
2	filed within the Hygiene. other then vent, the M	S	12		Home	mak	er						n Home	
and	B d a b ≥	Be	17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden	n Sumame)	
Ž	should be nd Menta marked umatic ev	2	Simeon Jalosky 19a. Informant's Nama/Relationship (1)	Funa (Reint)	105.44	-10		211			Drusky			
Ma	d 2 sho th and 7 le mu traum		Brenda Howard (Dau									-	or Town, State,	
Ġ,	s 1 and 2 should of Health and Mer Ilem 27 le marke other traumatic		20a. Method of Disposition	igricor /	20b. Place of Di	spositio	on (Name	of	1		THOLE,		land 21	
timo	permit. Pages Department of Important: If Ik any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	1)	Holly H	ill	Mem	. Ga	ard.	Nov.	10,2004	1 Bal		, Maryland
Ba	Departimon Important in 2000		21. Signature of Funeral Service Licen	500		22. Na B ru : 1 4 0	ame and Zdzi 7 Ol	Addres NSK 1 Ea	s of Facility Funda Isteri	eral n Ave	Home I	A. sex.	, Md. 2	1221
	Physician /Medical Examiner		23a. Party Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	a	ed the death. Do not	enter th	he mode	of dying), such as (cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
0,	te be executed ysician and te burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):									
68760,	rtificate be ng physicia as the bur	dlcai		d										
.O. Box	The law requires that the death certificat te has been signed by the attending phy tage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (XNo 9 □ Unknown		2 Fetel death		topic pred						23d. Date of de Month	livery Day Year
ds, P	puires that n signed b ild be deta	þ	Part II. Other significant conditions of	ontributing to death	but not resulting in th	unde	rlying cau	ise give	n in Part I.		23e. Did 1	•		o the cause of death?
Vital Records,	The law requir ate has been si page 2 should	Completed									24a. Was auto pend	an osy ormed? 2 No	24b. Were a prior to death?	utopsy findings available completion of cause of
ital		0	25. Was case referred to medicat						26. Place	of Death	1 ☐ Yes (Check only o	-	1 Yes	3 2 □ No
_ <	d is	To B	examiner? 1 ☐ Yes 2 🎇 No	Hospital: 1 tnpa	tient 2 ER/Outpa	ent :	3□ DOA	Othe	_				6 ☐Other (Spe	pcify)
ion of	ding After funer		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury 28b. Tim tnju	У	286 M	: Injury Work		2	8d. Describe			
Division	al or Attendi s after death.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of I	njury - At home, farm, etc. <i>(Specify)</i>	street,	factory,	office		2	8f. Location (City or To	Street an wn, State	nd Number or R	ural Route Number,
	To the Hospital or At within 24 hours after o To the Funaral Direct completely filled in by	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the besiner: On the basis and manner:	it of my knowledge, do of examination and/o stated.	ath oc	curred at tigation, in	the time	e, date and inion, deat	place, a	ind due to the ed at the time,	cause(s) date and) and manner as d place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	~			29c.	icense	number			29d. Dat	te signed (Mont	h, Day, Year)
	•		> W M	·)				PI	84	R7		11	18/02	1

State Registrar

PIDGE CIRCLE, BALTU, MD 21236

			1 - Stete RegistraMEND ITEM #18	tate of Ma	aryland .	/ Depa 1.1 <i>Ge</i>	artment of F <i>rtificaterof</i>	lealth and M <i>Death</i>		en2004	35391
	,		Decedent's Name (First, Middle, Last)	OFK PH	G03/	1170	9704 JH		2. Date of Death	1	3. Time of Death
	Physici /Medic		PAUL		Ρ.		FRIEDM	NA	NÖVËMBE	R 5, 2004	
	Examin	er	4a. Facility Name (If not institution, give stre		DICT (TD	4b. City, Town, o	r Location of Death		4c. County of De	
	Funeral		HOSPICE OF BALTIMOR 5. Social Security Number 6. Sex		KISI U		If Under 1 Year	TOWSON If Under 24 Hrs.	8 Date of Birth		TIMORE
	Director		217 - 12-3664 ¹₹ ^M		80	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, OCT.4,1	924	irthplace (State or Foreign Country) MD
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	ocation				10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f ehow	tor		IMORE	,,			REISTERST	TOWN .		1 ☐ Yes 2 ☑ No
	or 28a	Funeral Director	10e. Street and Number				10f. Zip Code	TETO I ETTO		g. Citizen of What (Country?
	23e c	ralD	211 FOX HAVEN COURT					21136			USA
	ler dea items	une		Was Decedent E Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
036	a o	by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:	10		1□Yes 21 No	Specify:		Specify:	WHITE
21215-0036	natural;	Completed	15. Decedent's Education (Specify only highest grade control of th	on moleted)	1	6a. Dece	dent's Usual Occup	ation during most of worki	ina 1	6b. Kind of Busines	s/Industry
121	within ene. then "	ldm		College (1-4or 5		life.	DO NOT use retired	1)	9	HOME TWO	DOVEMENT
	filed within Hygiene. Other than	ပိ	17. Father's Name (First, Middle, Last)			SALES	MAN	18. Mother's Name	(First, Middle, M	HOME IMP	RUVEMENT
Maryland	2 should be and Mental is marked ceumatic eve	To Be	HARRY			FRIE	DMAN	ANNIE	BECK	ER	BERKER
lar	2 sho and h is ma		19a. Informant's Name/Relationship (Type,		1			and Number or Rura			
	s 1 and 2 of Health item 27 l		LORRAINE FRIEDMAN / 20a. Method of Disposition	WIFE	20h Place		FOX HAVEN sition (Name of	COURT -	-		
Baltimore,	or = .		1	oval from State	RADOM	etery, crer	natory or other plac	^{⊛)} DGE	_	Oc. Location - City o	
altir	permit. Page Department o Importent: If eny injury or once.	1	21. Signature of Juneyal Service Licensee		KADUI			ss of Facility SOL		ROSEDAI N & RROS	
ä	permi Depar Impor eny ir	C 33	1 Jan 12			8	900 REIST	ERSTOWN F	ROAD - PI	KESVILLE	, MD 21208
п			23a. Part1. Enter the disease, or complication shock, or leart failure. List only one complications are complicated as a second	ons that caused ause on each lin	the death. [o not ent	er the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Priysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	Ischen			owel				Onset and Death
	Examiner			Due to (or as a	consequen	,	vian d	I house			years
		ner	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury that initiated events c	Tue to (or as a	t consideration						7 - 0 -
(0	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
60,	be ex ician burial	al E		Due to (or as a	a consequen	ce or):					
68760,	tificate be executed ig physician and as the burial-transit	edical	d								
Вох	The taw requires that the death certificate be exec the has been signed by the attending physician an age 2 should be detached for use as the burial-tr		230. Was decedent pregnant	f yes, outcome o			Ectopic pregnancy			23d. Date of de	
	the at	Physician/N		4□Pregnant at 9□ Unknown	time of death		Other (specify)			Month	Day Year
, P.O.	that the	y Ph	Part II. Other significant conditions contrib	uting to death bu	ıt not resultin	g in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute :	to the cause of death?
rds	w requires that been signed b should be deta	ed by							1 ☐ Yes	2 10 No 3 □ P	Probably 4 Unknown
Records,	ne taw re has bee ge 2 sho	Completed				_			24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
<u> </u>		Com							perform	ed? death?	s 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ital:			Othe	26. Place of Death			.1.00 =
ō	y Phys er this eral dir	n; To	T Tes 254 No	1 ☐ Inpatier 8a. Date of Injury (Month, Day		Outpatien Time of	28c. Injury	at 2	ne 5 Residen 8d. Describe how		ecity) (HOSPICE
ion	Attending r death. ector: After by the funer	atlo	2 Accident investigation	(Month, Day	rear)	Injury	M 1 🗆	(? Yes 2 □ No			
Division	or Atto	Certification;	3 Suicide 6 Could not be determined 2	Be. Place of Inju building, etc	ry - At home, . (Specify)	farm, stre	et, factory, office	2	8f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
	ours a		29a. Certifier Certifying Physicie	n. To the hest o	f my knowled	Ine death	occurred at the tim	a data and place a	nd due to the ear		
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Medical	(Check only 2 Medical Examiner:	On the basis of and manner stat	examination	and/or inv	estigation, in my or	pinion, death occurre	ed at the time, dat	e and place, and du	e to the cause(s)
	To the To the company	ž	29b. Signature and title of certifier	200			29c. License	number	290	L. Date signed (Mon	th, Dey, Year)
	j		Much				1 2 5	0)0>	No	wem ber	-> 2004
	Ø		30. Name and address of person who complete the complete	sted cause of de	eath (Item 23)	a) (Type. I	Print) horse	s st	Baltima	remD 2	1204
	Sta	te	31. Date filed (Month, Day, Year)								
	Registr	ar	NOV 0 9 2004	32. Registra	K B	porti					

Friedman, Paul

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 7:02 NOVEMBER Forsyth David 6, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Director Sept.30,1930 231-46-4524 74 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show 27 is marked other than "naturel", or items 23a or 28a-f sho treumstic event, the Medical Examena must be indiffed at **Funeral Director** 1 ☐ Yes 2 No Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21136 6524 Deer Park Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Stock Broker Investments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H ဥ Harry Forsyth Joan Whitridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health of item 27 l 6524 Deer Park Road, Reisterstown, MD 21136 Simonetta Citti Forsyth Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Importent: If any injury or once. 11/8/04 Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ine Eline Funeral Home Reisterstown, MD 21136 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im rediate Cause (Final Physician MITRAL REGURGITATION dis ase or condition sulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulscass or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s INTRA-ABDOMINAL BLEEDING autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 21 No 2 ER/Outpatient 3 DOA 1 🔀 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hour. 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOO. M. D... 32. Registrar's Signature FRANCIS TAT-TEE M. D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) NOV 0 9 2004 State Registrar

State of Maryland / Department of Health and Mental Hygien O Certificate of Death

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U	J	J	7	U

			1 - State Registrar		Certificate of Death						Reg. No.					
			Decedent's Name (First, Middle, Last)			C ALLA A 2. Date of Month					of Death 3. Time of Death					
	Physic /Medi		CAITLIN			GAHAN			1				00:15A M			
	Examir		4a. Facility Name (If not institution, g.	ve street and number)			4b. City, Town, o	r Location		e u e vri			v of Death	CC,137		
	Exami		The 1 hour 11	a al : 1	tich Baltimore City											
	Funeral			Sex , 7. Ag	(In yrs. last birt	thday)	If Under 1 Year	If Under	24 Hrs.	8. Date of B	irth	1	9. Birtho	place (State or Foreign		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland of peptirment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Machal Examiner must be notified at one.		398-54-3687	10 M 2/05E		Yrs.	Months Days Hours Min.			Month, L	Day, Year)		Cour	Country)		
			Usual Residence of Decedent							тер 14	, 1-	755	WIBCO	2112 111		
			10a. State 10b. County		10c. City, Town	or Loca	ation						1	0d. Inside City Limits		
		Funeral Director	MD Montgomery Bethesda										1 ☐ Yes 2 No			
			10e. Street and Number 10f. Zip Code							10g. Citizen of What Country?						
		<u>=</u>		" 405			,									
		rai	4970 Battery Lane			T	20814				1	,	State			
		n n	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Or an, Mexica	igin? (Spe n, Puerto F	cify Yes or N Rican, etc.)	10-	14. Race - American Indian, Black, White, etc.				
36		by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give	1 Yes 2 No		1 ☐ Yes 2 No Specify:					Specify:				
5-0036		D D		Year or Dates:									White			
ιά		Completed	15. Decedent's i (Specify only highest g	ducation rade completed)	College (1-4or 5+)		Decedent's Usual Occupation 'Give kind of work done during most of working life. DO NOT use retired)					Kind of Business/Industry		dustry		
2121		mp	Elementary/Secondary (0-12)								Fur	rniture				
2						-es										
2		Be	17. Father's Name (First, Middle, Las	t)		18. Mother's Nam										
<u>=</u>		2	William Gahan	Virginia				lnia	Hauptman							
Maryland		0 9	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing	Address (Street	and Numbe	er or Rural	Route Num	ber, City	or Town,	State, Zip	Code)		
≥			Tarna Gahan Hunte	er/Daughter	497	70 B	attery I	ane,	# 40	7, Bet	hes	da, N	4D 208	314		
<u>S</u>			20a. Method of Disposition		20b. Place of	Disposit	tion (Name of tory or other place	ا (م		ite	20c.	Oc. Location - City or Town, State				
Baltimore,			1 ☐ Burial 2 ★Cremation 3 ☐ Other (Spec				· 1	NO 20	v 9 04	Beltsville, MD						
를			'4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Wes 986 22. Name and Address of Facility Cremation and Fun													
ñ		100	X XII	0,11	100 600									MD		
			8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line.											Interval Between Onset and Death		
			disease or condition RUDTURED CEREFRINI ANEURUSIM													
			Due to (or as a consequence of):													
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Ti	certificate be executed iding physician and ise as the burial-transit	Examiner	Cause (Disease or injury that initiated events	CEREB	RAL EDEMA a consequence of):							3 00				
ó,			resulting in death) Last	Due to (or as a consequence of): d. INCREASED INTRACRAMIAL PRESSURE												
68760,	ite b iysic	/Medical										3 009				
99		Med	In the second of	-												
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy							23d. Date of deliv		te of delive	ry		
m	death e atte	icia	in the past 12 months?	4☐ Pregnant at	□Live birth 2 □ Fetal death 3 □ Ectopic pregnancy □ Pregnant at time of death 5 □ Other (specify)						Month Da			Day Year		
P.O.	The law requires that the death sie has been signed by the atter page 2 should be detached for u	hys	9 ☐ Unknown													
о.		Completed by Physicial	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of dea				e cause of death?		
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of Vital Records,	w requir been si should	ete						-		04= 146=		0.45	M			
3e	iician: The lav certificate has rector, page 2	g.								24a. Was	s an psy ormed2	1	vere autoporior to condeath?	ssy findings available appletion of cause of		
<u>=</u>	: Th cate	ပိ								1 ☐ Yes	2 N			2 🗆 No		
<u> </u>	Physician: rthis certifice ral director, p	Be	25. Was case referred to medical argument? 26. Place of Death (Characteristics)									heck only one)				
-to	Physi this c	٤	1 ☐ Yes 2 🔀 No			2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)										
Division o	ng P	ü	27. Manner of Death 1 ★ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how inju								ury occurr	ed			
	l or Attending after death. Diractor: After I in by the funer	ati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No												
<u>\S</u>	er de racte by t	ţį	3 Suicide 6 Could not determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (building, etc. (Specify) 28f. Location (City or To							(Street and Number or Rural Route Number, own, State)					
	s aft s aft in set in s	Certification;	Dily of Tomi, State)													
	hour hour uner ly fill		29a. Certifier Certifying P	hysician: To the best	of my knowledge,	death o	ccurred at the tim	ne, date an	d place, ar	d due to the	cause(s	s) and ma	nner as sta	ited.		
	To the Mospital or Attending Physician: The la within 24 hours after death. To the Funeral Diractor: After this certilicate has completely filled in by the funeral director, page 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.									and place, and due to the cause(s)				
		Σ	29b. Signature and title of certifier 29c. License number 2								29d. D	29d. Date signed (Month, Day, Year)				
}			Josh L. Duckworth, MD RES-000						,	NOVEMBER 6 2004						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
	10			JORTH (RA/	Tim	met 1	MI	7	128=	7		
	Sta	te.	31. Date filed (Month, Day, Year)	32. Megistra	ar's Signature	1.	1						- 0 1			
	Registr		31. Date filed (Month, Day, Year)	14 Bens	6	7	Sparks									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar 35394 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Clementine Henneuse November 8, 2004 1:10 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 X F Hours Min. Months Days 85 Director Yrs 319-32-7412 Belgium Oct 4, Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Nedical Evanther must be redified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2309 Chetwood Cir. Apt. 201 United States by Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Retail Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leopold Budts Rosalie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030Pages 1 and 2 s ment of Health an ent: If item 27 is: Vera R. Jensen/Daughter 321 Limestone Valley Dr. Apt. K, Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Nov 10 permit. Page Department of Importent: If any injury or once. Beltsville, MD Chesapeake Crematory 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives J8PODM 8717 Green Pastures Drive Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician (Metas HARC Bricast disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 25No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA (hiis funera 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Alter Division To the Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours a y certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

rander ST Baltrurze MD 21204

30. Name a d address of person who completed cause of death (Item 23a) (Type, Print)

32/ Registrar's Signature

CHARLES

State of Maryland / Department of Health and Mental Hygiene 2004 35395 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6, Nov. 2004 6:15 Geneva Μ. Hokuf /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Broadmead Cockeysville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | April 12,1910 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 □ M 2 🖸 F 94 Yrs. 505-30-4601 Director Nebraska Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or items 23e or 28a-1 show any injury or other traumatic event, I've Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13801 York Road 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No White þ Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 2 Elementary/Secondary (0-12) Homemaker Own Home 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ James Noel Grant Ona Bedford 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Old Troy Road Stephanie Pratt/ Daughter Wappingers Falls, NY 21590 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 11/12/04 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Washington Crematory Laurel, Maryland 21. Signature of Funeral Service Line ns-e Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or com shock, or heart failure. List only excomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, Approximate Interval Between Onset and Death one cause on each lin Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) P.O. Box 68760, Physician/Medical ed by the attending phys detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 2 Yes 2 1 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown this certificate has been signed by ral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? þ Records, 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2 10 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Loursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 29a. Certifie 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, and title of certifier 29c. License numbe 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Rd., Cockeysu 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11 **Physician** 2004 1:55 P M Mildred Rae Hager /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 9/28/1922 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1□M 2\ F 82 220-12-1562 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21060 USA 310 Norman Avenue Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County College (1-4or 5+) 5+ Elementary/Secondary (0-12) School System Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Edwin Johnson Hazel Josephine Byrd 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Norman Avenue, Frederick W. Hager / husband Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Chesapeake Cremation 11/5/04 Stevensville, MD ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Ave SW, 23a. Part 1. B. or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learl failure. List only one cause on each line. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition oti centra ZWW **Physician** resulting in death) /Medical Due to (or as Examiner Sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Brenna The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician long distase Physician/Medicai as the the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy ō Month Year Day 4☐Pregnant at time of death 5 Other (specify) be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Minknown peeu 24a. Was an autopsy performed? 1 ☐ Yes 2 ■ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ◯ No page 2 s has certificate or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Physician 00056950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8094 Edmin Raynor Blod Ste A, Pasadena MD 21122 Agajeln mp Nnaemeka 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 9 2004

DHMH 17 Rev 1/2001

			1 - For State Registrar		State of M	aryland		artment of F rtificate of			gien Reg. N	4004	35397
	Physici /Medic		1. Decedent's Name (First,		harles	Нос	ofnag]	e Jr.		2. Date of De Month NOVEMB		3,2004 Year	3. Time of Death 11:54A. M
	Examir		4a. Facility Name (If not ins	_					Location of Death		40	. County of Deat	
	Funeral		7975 CRAIN H 5. Social Security Number	LGHWA 6. S		je (In yrs. la:	st birthday)	GLEN BI	JRN LE If Under 24 Hrs.	8. Date of Birt	- 1	NNE ARUN	
	Director		216-24-5509		KXM 2□F	74	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 12/5/1	29°	Col	nplace (State or Foreign untry) MD
	and and		Usual Residence of Deceder 10a. State 10b. C			10c. City,	Town or Lo	cation					10d. Inside City Limits
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920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or Items 23e or 28e-f ehow event. The Medical Exafring counties a confiled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div		12. Was Decedent Armed Forces 1 \(\Delta\) Yes 2 \(\Delta\) If Yes, Give Year or Dates:	Ever in U.S. No	i i	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2점 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify:	
5-0	72 ho netur	eted	15. Dec (Specify only	edent's Ed	lucation de completed)		16a. Deced	dent's Usual Occup	ation during most of work	ina	16b. H	(ind of Business/I	ndustry
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/lan	should be ind Mental imarked o	To B	Charles	Ноо	fnagle	Sr.			"unkr	nown''			
, Maryland 21215-0036	nd 2 shallth and 27 is m		19a. Informant's Name/Rela					ng Address <i>(Street a</i> rfield Co				or Town, State, Zi .811	ip Code)
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1			cen	netery, cren	sition <i>(Name of</i> natory or other plac n Cemeter	9)	Date (ocation - City or T Burnie,	
Balt	permit. Pag Department Importent: h eny injury o		21. Signature of First I Se	rviee Licen	. moj	319	1	. Name and Address	s of Facility Sive SW Gle	ngleton en Burni	Fun e M	eral Hon 0 21061	ne P.A.
À			23a. Part1. Enter the disea shock, or heart failure	se, or comp List only	ofications that caused one cause on each li	the death.	Do not enti	er the mode of dying	g, such as cardiac	or respiratory an	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a. Intro	roul	Jue	what	Vongol				Onset and Death
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		fedical	Is service		u,								
.O. Box	The law requires that the death certi lie has been signed by the attending rage 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	ery Day Year
Δ.	es that gned b	by PI	Part II. Other significant co	nditions co	ontributing to death b	ut not resulti	ing in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco t	use contribute to t	he cause of death?
ord	w requires t been signe should be									1 🗆 Y	es 2	□ No 3 □ Prob	bably 4 Unknown
al Records,		Completed								24a. Was a autops perior 1 Yes	ned?	prior to co death?	opsy findings available ompletion of cause of 2 No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to me examiner? 1 Yes 2 No		Hospital:	ما در	2/0-4	Othe	26. Place of Deati				AS 100
l of	g Physer this seral di	\vdash	27. Manner of Death		1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 28	8b. Time of	28c. Injury	at	me 5 Aeside 28d. Describe ho		6XOther (Special of the Control of t	W SCENE
sior	Attending r death. Bctor: After by the fune	atlo	2 Accident in	ending vestigation	Freid 11/3	1 6	Injury	4 M 1□Y		Sulpi	+ 50	of self	
Division	or Att	Certification:		ould not be stermined	28e. Place of Inj building, et	ury - At home c. (Specify)	/			28f. Location (Si City or Town	reet an n, State	d Number or Rura アクチン (al Route Number,
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			I huest	- le	160-	-n/2		0.0	.M.E.	, n	[∩t π	MBER 4,2	2004
	1.		30. Name and address of pe			eath (Item 2	За) (Туре, Р	Print)					
	(O		31. Date filed (Month, Day,	ear)	ZIP 32. Registra	ar's Signatur		111 Penn	outeet,	Daltimoi	e,	Maryland	1 21201
	Sta Registr		NOV 0 9		Berlin	1	9 A	books					

			1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H rtificate of L	lealth and N Death	R	eg. No.	2004	3539	8
	Physici	an	1. Decedent's Name (First, Middle, Last) Judy A. Heple	r				2. Date of Dea Month October	Day	2004	3. Time of Death 4:30 PM	,
}	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	occobei		County of Dea		_
	- Admini		75 Willow Spring	Road		Dundal	.k			Balti	more	
	Funeral		5. Social Security Number 6. Sex	M men =		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Bir	thplace (State or Foreign	n
gia	Director		Usual Residence of Decedent	36	Yrs.			FEG.10.	1988	1610	37/4 VO	_
	yland how		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits	ŝ
	e Ma	Director	MARYLAND BALTIMOR	<u>Z</u> <u>D</u>	anu	ALK					1 ☐ Yes 2 No)
	with th		10e. Street and Number	0.5		10f. Zip Code		1		en of What Co	ountry?	
	leath v	Funerai	11. Marital Status	12 Was Decedent Ever in U.S	3. 13.1	Was Decedent of Hi		ectfy Yes or No-		. S. A.	ancen Indian	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Misportant: if tem 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinal must be notified at once.	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 45 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 Tyes 25 No	n, Mexican, Puerto Specify:	Rican, etc.)		Black, Whit	e, etc.	
2-0	72 hou	sted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind	d of Business		
21215-0036	within 7 iene. 'then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired)	mg .				
22	filed w Hygiei ther ti		17. Father's Name (First, Middle, Last)		_VV2	Telbrox	18. Mother's Nam	e (First Middle I	Maiden S	umama)		
au	Mental i	To Be	William HAROL	a HARLESS.	CR		Tio	LIZAGI		REINN	E ()	
	2 should and Mer is marke aumatic	—	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street a	and Number or Run	al Route Number	City or	Town, State,	Zip Code) 21222	
	l and 2 fealth a im 27 is her trai		JOANN PORTA		MZE	MEWSON	into Road	Dunge	TKJ	MARYL	padollo Ovy	
ore	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Re	20b. Pla emoval from State	ace of Dispo	sition (Name of matory or other place	P. YON	Date	20c. Loca	ation - City or	Town, State	
	permit. Pag Department Important: I eny injury o once.		*4 □ Donation 5 □ Other (Specify) 21. Signative ■ Funera Service License	0 1 632	LHIR.	P.A.	20			72 74.77)
Ba	permit. Departr Importu eny inji		I was three	1	Pi		1 040%	imorio	m.r			\
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	ecause on each line.	. Do not ent	A	4				Approximate Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a conseque	n	art-	my Ch	SCase			years	
a	Examiner			Diahe.	to c						month	и
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):							9
K.	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Hyper		1-					Yea 5	
68760,	ficate be executed physician and s the burial-transit	al E	resulting in additify East	Due ras a conseque	ence ot):	1					years	
687	ifficate g phys as the	edical	d								7,000	_
Вох	eath certii attending for use a	M/us	230. was decedent pregnant	3c. If yes, outcome of pregnan		Ectopic pregnancy			23	d. Date of del	ivery	
P.O. B	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnant at time of dea 9☐ Unknown		Other (specify)				Month	Day Year	
م	that the by detach	by Ph	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use	contribute to	the cause of death?	
rds	w requires t been signe should be	ed b						1 □ Y€	s 2 🗆	No 3∏Pr	obably 4 Munknown	ı
eco	law re as be	Completed						24a. Was ar		24b. Were au	topsy findings available	9
<u>س</u>	: The la	Con						perform	ned?	death?	2 No	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		• 3CI DOA Othe	26. Place of Death					-
ō	y Phys er this eral di	n: To	1 Yes 2 No	28a. Date of Injury	28b. Time of	1 3 DOW	4 Nursing Ho	me 5. Reside 28d. Describe ho			afy)	-
ion	ath. r: After ne funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		r? res 2 □ No					
Division of Vital Records,	or Attending Physician: ifer death. Director: After this certifics in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (St. City or Town		Number or Ru	iral Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	ician: To the best of my know	Indea death	a aggregat at the time	o data and place	and due to the co				
	ne Hos h 24 h ne Fun iletely	edical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	on and/or in	estigation, in my op	oinion, death occurr	ed at the time, da	ite and p	lace, and due	to the cause(s)	
	To th Comp	Me	29b. Signature and title of certifier	A 4 3		29c. License				signed (Montl		
)			//	D MD		Doc	5+64	+	11	2/04	†	
	2	1	30 Name and address of person who con		23a) (Type,	Print)	- portert) 4 mal = 11	20	12 Du	ndak Ave	,
	Sta	te	31. Date filed (Month, Pay Year) 9 21	32. Registrar's Signati	TOPIC	inous	orcour y	runda 11	-13	2117mg	VEIVIT 2122	_
	Registr		NUV U 9 ZI	32. Registrar's Signatu	1	Span	Carl .					

			1 - State	State of M	laryland /	-			ealth a	and M			001	05000
	Physici	an	Registrar 1. Decedent's Name (First, Middle, La William	st) Felix	Hu	ighes			Journ		2. Date of De Month	Day	Year	3. Time of Death
ı	/Medio Examir		4a. Facility Name (If not institution, given 1400 Elkton Boule	e street and number	···	ignes		Town, or	Location of	of Death	Novemb	4c. C	2004 County of Deat Cil Co	
	Funeral Director		5. Social Security Number 6. S 044–54–3623 Usual Residence of Decedent	6ex 7.A	ge (In yrs. last 49	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir July 2	th.	9. Birti	nplace (State or Foreign untry) necticut
	death with the Maryland ms 23a or 28a-f show f.i.wat be notified at	Director	10a. State 10b. County Connecticut unk 10e. Street and Number	nown	10c. City, To	own or Lo	10f. Zip						en of What Co	*
215-0036	should be filed within 72 hours after death with the Marylar of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examinimations to Items the Incition at	eted by Funeral Director	6 Timber Lake Roa 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Morried 15. Decedent's E (Specify only highest gra	12. Was Deceden Amed Forces 1 ☐ Yes 2★ If Yes, Give Year or Dates:	? INo	6a. Deced	Vas Deced Yes, spec	2 No	spanic Origin, Mexican		ocify Yes or No Rican, etc.)	- 14	ted Sta 1. Race - Amer Black, White Specify: W	rican Indian, a, etc. hite
2	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	Driv	se retired,						ortation
Maryland	should be filed nd Mental Hygi markad other martic event, I	To Be	John Hughes 19a. Informant's Name/Relationship (-	Ob Mailin	- Address	(Carana)	Ma	ary	(First, Middle,	Ant	hony	
	es t and 2 of Health ar fitem 27 is r other trau		Ms. Maria Haussh 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	err-Hughe	s/Ex Wi	fe of Dispos	Tim	iber	Lake	Rd.,	Sherma	an, C	onnect:	icut 06784
Baltimore,	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (Specification of Fundamental Section 1) Of the Company of Fundamental Section 1) Of the Company of Fundamental Section 1) Of the Company of the	The state of	M01113	22	Name an	d Addres	s of Facility	y F		Funer	al Serv	Maryland vice, P.A.
8/60,	whysicien and with the burial-transit in burial-	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	d the death. D	ce of):	er the mod tis	of dying	des	cardiac o	r respiratory ar	stul	z.	Approximate Interval Between Onset and Death
O. Box 62	that the death certifics led by the attending pr detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		of pregnancy 2 Fetal dea It time of death		Ectopic pro Other (sp					230	d. Date of deliv	rery Day Year
rds, P.	The law requires that: ite has been signed bi age 2 should be deta	by	Part II. Other significant conditions of	ontributing to death I	out not resulting	g in the un	derlying ca	ause give	n in Part I.		23e. Did to	Δ.	4	the cause of death?
al Kecord	(D)	Completed								_	24a. Was a autop perfor	sy	24b. Were auti prior to co death	opsy findings available ompletion of cause of 2 No
VITal		o Be	25. Was case referred to medical examiner? 1∑ Yes 2 □ No	Hospital:	0 TER/	Outpatient	20.00	Other			(Check only or			
lon or	nding Phys tth. :: After this e funeral di	-	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b	Time of Injury		Bc. Injury Work	4 LI NUI	2	8d. Describe h			M) At scene
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not by 4 ☐ Homicide determined	28e. Place of In	jury - At home, tc. (Specily)	farm, stre	et, factory	, office		2	8f. Location (S City or Tow	treet and f n, State)	Number or Rur	al Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	edicai	one) 25 PMedical Exam	ysician: To the best niner: On the basis o and manner st	of examination a	lge, death and/or inv	estigation,	in my opi	nion, deatl	l place, a h occurre	nd due to the d d at the time, d	ause(s) ar late and pl	id manner as s ace, and due t	stated. o the cause(s)
	To To	Σ	29b. Signature and title of certifier	0				License					igned (Month,	,
	h		30. Name and address of person who	Cell)	death (Item 23a	, .	rint)	OCME		•			iber 3,	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2004	32. Registi	rar's Signarare	111 1	Penn	Stre	et, E	Balti	more, N	(ary)	and 212	201

			1 - For State Registrer	State of M	aryland .		ent of He		Mental H	ygien Reg. N	711111	35400
	Physic /Medi		Decedent's Name (First, Middle Thurman Sylv		n Sr.				2. Date of D Month	eath	ay Ye	3. Time of Death
	Exami Funeral Director		4a. Facility Name (If not institution FRANK IIN Sq	give street and number) UARE HOS			Rose al	Location of Dea	8. Date of B	irth Day, Year	C. County of D (B4/7) 9.1	eath M.C.P. = Birthplace (State or Foreign Country)
			Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Location			2/22	/192	5	LA 10d. Inside City Limits
	the Man 28a-f sh	Director	MD Baltim	ore	Whit	te Marsh	-					1 ☐ Yes 2 No
	ath with 23a or	rai Di	5519 Forge Rd				. Zip Code 21162				itizen of What U.S.A.	Country?
9036	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Items 23a or 28a-f show int, Ite Madical Exerticer must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2X Marri 3 □ Widowed 4 □ Divorced	If Yes, Give			3.7	panic Origin? (S , Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Al Black, W Specify: W	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important: If itam 27 ia markad othar than "natural", any injury or othar traumatic evant, the Madical Eva once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5		IIfe. DO NO	f work done du T use retired)	ring most of wo	rking	16b. I	Kind of Busines	ss/Industry
nd 2	al Hygie t othar	Be Co	17. Father's Name (First, Middle, L	ast)		Meltir	g Foren		me (First, Middle		Steel n Sumame)	
Maryland	hould bid Ment	To E	Julian Evans Ho 19a. Informant's Name/Relationsh			Ob Mailin And	(2)		ce (Boon			
	and 2 sauth an n 27 ia		Eleanor Hogan/w		'		orge Ro		Marsh,			, Zīp Code)
Baltimore,	Pages 1 ent of He nt: If itan		20a. Method of Disposition 1 □ Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp	3 □Removal from State	ceme	of Disposition tery, crematory	or other place)		Date	20c. L	ocation - City	
Balti	permit. I Departm Importa any inju		21. Signature of Funeral Service L		TOLLY.		and Address	CV	2004 ACH/ROSEDA AORE, MD 2	ATE FI	ldle Riv UNERAL H	
8760,	Physician /Medical Examiner	dicai Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. A S c ul. Due to (or as a c.) Due to (or as a c.) Due to (or as a c.) Due to (or as a c.) Due to (or as a c.)	bRA a consequence a consequence AR	FNF, b Rill. Demen	ARCT	such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
P.O. Box 6	death certiff e attending od for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 19 ☐ Unknown	2 Fetal dea	th 3 ⊟Ectopi 5 ☐ Other	c pregnancy (specify)				23d. Date of de Month	alivery Day Year
Records, P	w requires that the been signed by th should be detache		Part II. Other significant condition	s contributing to death bu	t not resulting	in the underlyin	g cause given i	in Part I.		obacco u Yes 2	_	to the cause of death?
tal Rec	The lasate has	e Completed	25. Was case referred to medical						1 ☐ Yes	rmed? 200 No	prior to death?	utopsy findings available completion of cause of
of Vital	S S	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 1 Inpatier			Other		th <i>(Check only o</i>		6 □Other (Spe	ecify)
ion	Jing After fune	ation:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe h	ow injur	y occurred	
Division	i Difte	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be ed 28e. Place of Injurbuilding, etc.	ry - At home, t	farm, street, fact	ory, office		28f. Location (S City or Tow	Street and m, State,	d Number or R)	ural Route Number,
	To tha Hospital within 24 hours a To tha Funaral I completely filled	1	29a. Certifier (Check only one) 1 Certifying	Physicien: To the best of caminer: On the basis of and manner state	f my knowledg examination a ed.	ge, death occurr nd/or investigati	ed at the time, on, in my opinio	date and place, on, death occur	and due to the d red at the time, d	cause(s) date and	and manner as place, and due	s stated. a to the cause(s)
N	To th To th comp	Me	29b. Signature and title of continue	/2221		-	29c. License nu	ımber	/	29d. Date	e signed (Mon	h, Day, Year)
7	15	-	30. Name and address of person with	to completed cause of dea	ath (Nem 23a)	(Type, Print)	D5	4 13	6	11-	4-2	004 Md. 21237
	1		DRI KAM YOU A	uyeyng 9K	DO FR	PANKli	N Spi	LARE	DR. BA	4/Ti	MORE	Md. 21237
	Sta Registra	e ar	31. Date filed (Month Day, Year) NOV 0 9 200	4 Electron	Signature	book						

			1 - For Amend Item 10	<u>) State of Manyland / Der</u> Ce	<u>Pagment of H</u> ealth and N e <i>rtificate of Death</i>	Mental Hygier	2004	35401
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	/Medic			enkins		November		1015A M
	Examin Funeral	er	4a. Facility Name (If not institution, give : Franklin Squa 5. Social Security Number 6. Sex	re		8. Date of Birth	4c. County of Death	more
· ·	Director		334-78-6757 15	M 200 F 29 Yrs.	Months Days Hours Min.	(Month, Day Yea	75 cou	place (State or Foreign intry)
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Maryl	to	MD Pattin	nore	FRRAN			1 □Yes 2 No
	or 28a	Director		adwick Drive	10f. Zip Code 21221	10g. (Citizen of What Cou	intry?
	ath wi	rai	2079 Jessica M	lay, N	2021		USH	
	ltems refr	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. 13 Aimed Forces? 1 □ Yes 2 1 No	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
036	hours after death with the Maryland tural', or Items 23e or 28e-f show al Examinar must be notified at	þ	3 □ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	ACK .
21215-0036	72	Completed	15. Decedent's Edu (Specify only highest grade	completed) (Giv	edent's Usual Occupation we kind of work done during most of work	ding 16b.	Kind of Business/Ir	ndustry
121	within ene. then "	dmo	Elementary/Secondary (0-12)	College (1-40) 5+)	DO NOT use retired)	T	and Se	rvice
	illed I Hygi other	0	17. Father's Name (First, Middle, Last)	1011	18. Mother's Nam	e (First, Middle, Maid		rvice
/lar	2 should be and Mental Is marked c	To B	Jonathan Jenki	ns	KYONC	A H. S	ouna	
Maryland	2 sh and and aum		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mai	iling Address (Street and Number or Ru	I Route Number, City	or Town State, Zi	Code)
	s 1 and f Health item 27 other tr		20a. Method Disposition	V (MOTT) CK 20b. Place of Disp	position (Name of	Date 20c.	Lication - City or T	own. State
ē	m O		1 ☐ Burial 2 【V Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Green	ematory or other place) M(X) n+	0-04 P	attimore	a mn
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service License			ughncor	eere Fu	deval sincs
	89 E 29		· Vaugmi	2	3728 Liberty Kd,	Kandalk	JUNN D	10 SU33
194			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do not enter cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	•	Approximate Interval Between Onset and Death
.6	Physician / /Medical		disease or condition resulting in death)	Tutraventricular Due to (or as a consequence of):	an Bleeding of t	he Brai	~	ZUhrs
,	Examiner		Sequentially list conditions		*			
	De is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
•	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760	the death certificate be execut y the attending physicien and Iched for use as the burial-tra	dical						
9	n certificate anding phys use as the	Med	IF FEMALE:					
Вох	attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy		23d. Date of deliver	ery Day Year
P.O.	that the de ed by the a detached	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 5 9□ Unknown	Other (specify)			
	that ed b deta	by Pr	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23a. Did tobacco	use contribute to t	ne cause of death?
Vital Records,	The law requires the has been sign bage 2 should be	ted				1 🗆 Yes	2□No 3□Prob	pably 4 Unknown
Seco	e law r has be je 2 sh	Completed				24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
alF	(0		25 Mag age relevant to made at			performed? 1 ☐ Yes 2 ▼ N	death? lo 1 ☐ Yes	200 No
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	ospital: 1 Inpatient 2 ER/Outpatie	Other	me 5 Residence	6 □Other (Special	
0 0	ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at	28d. Describe how inj		77
sio	Attending r death. ector: Atte by the fune	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No			
Division of	l or Al after d Direc	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura te)	d Route Number,
	ospite hours unerel ly filled		29a. Certifier 1□ Certifying Phys	ician: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the cause(s) and manner as s	tated.
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only one) 2x Medical Examin	er: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occuri	ed at the time, date a	nd place, and due to	the cause(s)
)	5 # 5 8 P		29b Signature and title of certifier	1 - 1 /4	29c. License number	i i	ate signed (Month,	
/			30. Name and address of person who con	mpleted cause of death (Item 23a) (Type	018667	No	vemser	6 2004
	119							
)	(10		PH:1: p M: 1: 4e 1	A	ble Hill CT. Lut	heru; lle,	MD SIC	6,2004

		_	State of Maryland / Department of Health and I per Dr., G837,11,09/2004dhb Certificate of Death		en2 0 0 4	35402
	ysicia Viedic		1. Decedent's Name (First, Middle, Last) Al fonso John Jones	2. Date of Death	26 84	3. Time of Death 11:45 QM
	amin		4a. Facility Name (If not institution, give street and number) Bon Secours Hospital 4b. City, Town, or Location of Death Baltimore	1.	4c. County of De	ath
Fun Dire	eral ctor		5. Social Security Number 6. Sex 19-88-8307 1. Age (In yrs. last birthday) 1. Age (In yrs. la	(Month, Day)	9. B 1966 Mar	irthplace (State or Foreign Country) Cyland
ryland	iai		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore	, ,		10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show	a natifies	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What C	1 ☑ Yes 2 ☐ No
death wil	Country	Funeral D	3212 S. Gulfport Drive 21225 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S)	pecify Yes or No-	USA 14. Race - Arr	
5-UUSO 72 hours after or Itel	avent, the Medical Examinet must be notified at	þ	Amed Forces? If Yes, specify Cuban, Mexican, Puerton 1 New Married 2 Married 1 Yes, Sive 1 Yes, Give 1 Yes 2 No Specify:	o Rican, etc.)	Specify: B	
within 72 ho ene. than "natur	Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	kina	Sb. Kind of Busines	s/Industry esh Market
ba filed with	ent, the		10th grade Meat Cutter	ne (First, Middle, Ma M. Wall		
Mer Mer		To Be	nenty cones			7in Godob + 0 0 0
e, Mi	thar tr		19a. Informant's Name/Relationship (Type, Print) Diane Jones Montgomery/Sister 318 S. Parrish 20a. Method of Disposition 20b. Place of Disposition (Name of			1123
BAITIMORE, permit. Pagas 1 a Department of Hes Important: If Item	ury or of		1⊠ Burial 2 □ Cremation 3 □ Removal from State Mt. Carmel Cemetery 11/	2/04 Dui		Maryland
Dermit. Depart	any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cha 5240 Reisters fow	tman-Ha	rris Fur Ifimore	neral Home Md 21275
Physic	cian		21a. Ppn1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac nock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. ENCEPHALOPATHY	or respiratory arres	t,	Approximate Interval Between Onset and Death
/Med Exam	lical		disease or condition resulting in death) a			2_ NIONITS
pet	nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
Cate be axecuted physician and		ai Examin	that initiated events resulting in death) Last Due to (or as a consequence of):	-		
C 68/6U artificate be a	e as the l	Medicai	IF FEMALE:		1	
HECORDS, P.O. BOX of The law raquires that the death cartiff the has been signad by the attending.	ba detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Licke birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 Unknown 5 Unknown		23d. Date of de Month	alivery Day Year
S, P.C es that th gnad by	ba detact	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZUBE DISCRUER	23e. Did toba	. /	o the cause of death?
raquii	hould	ompieted	NEUROGENIC FEVER	1 ☐ Yes 24a. Was an	24b. Were a	robably 4 Unknown utopsy findings available
- 10	0	e Com	DIABETES MEULITUS 25. Was case referred to medical 26. Place of Deal		death?	completion of cause of
Phys this	P G	To B	examiner?	th (Check only one) ome 5 Residence 28d. Describe how		ecify)
DIVISION I or Attending after death, Director: After	the fune	ertification;	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
LINI Ital or Al	led in by	Certif	4 Homicide determined building, etc. (Specify)	28f. Location (Stree City or Town, S	State)	, i
UIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	completely filled in by	edical	29a. Certifier (Check only one) 1 [P Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the caus red at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
To 1 with	СОП	Σ	29b. Signature and first of certifier M.D. 29c. License number D 0057693		Date signed (Mon	p, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Print) MARK ATTA MD. BUN SECOMBALT MY HUSBITA	2080	W. Ba	Stimple St
Re	Sta gistra		31. Date filod (Month, Day, Year) NOV 0 9 2004 Service Signature	- 2001		, V, J

neg. No.	-	For Stata Registrar	State of Maryland / Department of Health and Mental Certificate of Death		_
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		•	For Stata Registrar	Otate of Maryli	Сел	tificate of	Death		en 2 0 0	4 35403
Pl	hysicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h	3. Time of Death
. /	Medic	al .	Norman Car 4a. Facility Name (If not institution, give s		ause	4h City Town	or Location of Death	October	30 20 4c. County of	04 11:55 A ^M
-	xamin	er	Shady Grove Adver		al		kville	'		gomery
	neral ector		5. Social Security Number 6. Sex 319-14-5217		rs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, June 2,	Year)	9. Birthplace (State or Foreign Country) Illinois
and		}	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
the Marylar	flad	to	Maryland Montgom	ery		Derw	vood			1 □ Yes 2XXNo
ith with the	in serioust ke notified at	Funeral Director	10e. Street and Number 16529 Baederwood	Lane		10f. Zip Code	20855	10	og. Citizen of Wh	at Country? d States
36 after des		by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White
15-0036 72 hours aft	edical Exe	eted	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	lent's Usual Occup	pation	kina	6b. Kind of Busi	ness/Industry
2121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of word)			•
d 22 filed v Hygie	evant, tre		17. Father's Name (First, Middle, Last)	5+		nemicai	Engineer	ne (First, Middle, M		Government
ld be	tic ev	To Be	Siegfried	Krause			Anita		,	5/4.1
Maryland 2 d 2 should be filed v th and Mental Hygie	othar traumetic		19a. Informant's Name/Relationship (Typ		1			ral Route Number,		ate, Zip Code)
≥ ≥ ≥ ≥	3 2	-	Michael Krause /				- 14114	ver Sprin	0.	20902 ty or Town, State
nor ages ant of	5		1 ☐ Burial 2 【XCremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	mioval nom State		sition (Name of natory or other place	ce)			sville,MD
Baltimore, permit. Pages 1 ar Department of Hea	any injury once.		21. Signature of Funeral Service Deense		22	Name and Addre	ess of Facility			sville, rib
n 888	2 8		Stole A John	rame Mo	0382 9	33 Gist A	ve., Silv	mation Se ver Sprin	g, MD	20910
Physi /Med Exam	dical niner	<u>.</u> .	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	sequence of):	and in the mode of dying and dying and dying and dying and dying and dying and discount and dying and dying and dying and dying and dying and dying and dying and dying and dying and dying and dying and dying and dying and	ng, such as cardiac In factorial	seasc	st,	Approximate Interval Between Onset and Death
rificate be executed		Medical Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons		/				
W	20 6	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 [Ectopic pregnancy Other (specify)	4		23d. Date o Month	,
cords, P.	should be deta	by	Part II. Other significant conditions cont	ributing to death but not	resulting in the un	derlying cause giv	en in Part I.		acco use contribu	ute to the cause of death?
I Reco	page 2	Completed						24a. Was an autopsy perform 1 Yes 2	ed? prio	re autopsy findings available in to completion of cause of th? Yes 2 \sum No
of Vital F Physician: Th	irecto	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2	ER/Outpatient	Oth		th (Check only one		
C gu	ineral	\vdash	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year,	^	28c. Injur	4 Nursing H	ome 5 Residen 28d. Describe how		Specify)
Division tel or Attanding rs after death.	ed in by th	Certification:	3 Suicide 6 Could not be 4 Hornicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	or Rural Route Number,
Division To the Hospitel or Attendi within 24 hours after death. To the Fundral Director A	npletely fil	edicai	(Check only 2 Medical Examin- one)	cian: To the best of my ker: On the basis of examand manner stated.	knowledge, death ination and/or inv	estigation, in my o	pinion, death occur	red at the time, dat	e and place, and	I due to the cause(s)
To	000		29b. Signature and title of contifier	Vool	M	29c. Licens	e number	0	d. Date signed (A) $C + BC$	Month, Day, Year) R 30, VOOY
	p	11	30. Name and address of person who in William Dooley M.D	,		*	Rockvill	Le, MD	20850	/

State Registrar 31. Date filed (Month, Day, Year) NOV 0 9 2004

32. Registrar's Signature

Sparke

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 8/2004 **Physician** Ruth L. Krout /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Towson Baltimore Manor Care Ruxton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. June 1, 1912 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthdav) **Funeral** 1 □ M June 212-07-4616 92 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Items 23a or 28a-f ehow the Medical Examiner must be notified at Towson 1 Tes XX No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA 7001 N. Charles Street Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after Hygiene. 1 □ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 🗓 No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail Sales other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event sones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Derry Groves Julia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Glenamov Road #202 Lutherville Maryland 21093 Gloria Bortz Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 11/09/2004 Baltimore, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Carchiovascular **Physician** Atherosclerunc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to minimoral cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, attending physicien Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2√2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 1 ANatural 5 Pending after death.

Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direct 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 1)43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BackRiver Neck MAHMOOD 201-109 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 35405 State Registrar AMEND ITEM #19a oer fh g837 Garjifigate of Peath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 4, 2004 **Physician** SHIRLEY 10:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8005-B TOWNSHIP DRIVE OWINGS MILLS BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea MAY 18, 1 Birthplace (State or Foreign Country) 1 □ M 2 🖬 F 214-22-1694 Director 76 Yrs. MD Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location itam 27 is markad othar than "natural", or itams 23a or 28a-f show other traumatic evant, Ita Medical Examinar must be notified at 10d. Inside City Limits Director MD BALTIMORE 1 ☐ Yes 2 No OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8005-B TOWNSHIP DRIVE Completed by Funeral 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Innt of Health and Mental Hygiene. Innt: If itam 27 is markad othar than "natural", or ita 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ISADORE** WOLF UNKNOWN HANNAH 19a Tay Tay S Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **IRVIN** KRAMER / SON 13 HIGHLANDS COURT - OWINGS MILLS, MD 21117 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ö permit. Page Department of Important: if any injury or once. (ANSHE EMUNAH AITZ CHAIM) 11/5/04 * 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG Physician CANCER 415 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient After this 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funaral Director: A Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/4/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COHEN, MP. 65-69 N. CHALLET 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NOV 0 9 2004

			For State Registrar	State of Marylan		partment of Hertificate of L			iene () ()4	35406
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Yeer	3. Time of Death
	/Medic	al	A. Gayle W.	Keeney				NOVEMBE	1	40 1 10 100 100 Tag	7:30 FM
	Examin	er	4a. Fecility Name (If not institution, give	Medical Cen	iter		Location of Death		4c. County	Balt	imore
	Funeral Director		5. Social Security Number 6. Se 1[x 7. Age (In yrs. I	last birthd Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 28	Year)	9. Birthp	place (State or Foreign atry)
	D		Usuel Residence of Decedent					NOV. 20	, 1945		MD
	arylan ehow	_	10a. State 10b. County		y, Town o					1	0d. Inside City Limits 1 ☐ Yes 2X No
	the M	Director	MD Baltim 10e. Street and Number	ore (Cocke	ysville 10f. Zip Code		1/	og. Citizen of V	Albeit Cour	
	With With		12317 Cleghor	n Pood		2103	0		USA		itty?
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 1	i3. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Rac	e - Americ	
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f ehow the Medical Examinar must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 Yes, specify Cuba	n, Mexican, Puerto Specify:	Hican, etc.)	Specifi	ck, White,	etc.
8	hours ural',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	10.5					Wl	nite
7	in 72 "nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(G	ecedent's Usual Occupa live kind of work done o e. DO NOT use retired	furing most of work	ing	6b. Kind of B	usiness/Ind	dustry
212	d with jiene. rr thar	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		Sales			Flow	er Sl	nop
P	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-1 ehow aumstic event, the Medical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M			
ya	Ment Ment Markec	2	Harold L. Webb					a T. Ris			
Maryland 21215-0036	12 sh hand 7 ts m traum		19a. Informant's Name/Relationship (T)		20755	ailing Address (Street a			VOVE DESCRIPTION	1989	Code)
ē,	permit. Pages 1 and 2 should by Deperment of Health and Menta important: if item 27 is marked any Injury or other traumatic evense.		Richard Scott Mabr 20a. Method of Disposition	20b. P	lace of Di	Little Kno sposition (Name of			FA 173 Oc. Location -		wn, State
Ö	Pages ent of nt: If ii		1 ☐ Burial 2 XCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify,	Removal from State	-	crematory or other place Cremation	11/5/	04	Hampst	o o d	MD
Baltimore,	permit. I Depertm Importal any Injui		21. Signature of Funeral Service Licens	Dari	LULL	22. Name and Addres		11824 Re			
<u>m</u>	88 28		Kalfry D	Line		Eline Fune		Reisters	stown,		
			23a. art1. The the difease, or comp shock or eart fy ure. List only of	lic flions that caused the death ne cause on each line.	n. Do not	enter the mode of dying	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate ause (Final discase or condition resulting in death)	a. INTRACEREI	BRAL	BLEED					Oriset and Death
	/Medical Examiner		1	Due to (or as a consequ	uence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):					-	
	cuted nd ransit	Examiner	that initiated events	С.							
, 0	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	cate b	dicai		d.	-			.			
9 X	The law requires that the death certificate be executed attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregna	incy				334 Day	te of delive	in.
Box	death a atter d for u	Iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death	3 Ectopic pregnancy 5 Other (specify)			Mo		Day Year
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ord	w require been si	ted	METASTATIC (CHONDROSARCOMA	<u> </u>			1 🗌 Ye	s 2 No	3 🗌 Prob	ably 4 Unknown
Division of Vital Records,	e law has b	Completed						24a. Was an autopsy perform	' r	Were autor prior to con death?	osy findings available in pletion of cause of
<u>a</u>			00 111-					1 ☐ Yes 2	No 1	Yes	X No
Σ	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: Minpatient 2	ER/Outpa	tient 3 DOA Othe	26. Place of Death	n <i>(Check only one</i> me 5 ☐ Resider		or (Specifi	()
o	g Phya ler this neral dii		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	e of 28c. Injury	at	28d. Describe how			7
Š	ttending P death. ctor: After y the funer.	Certification;	1 Natural 5 Pending 2 Accident investigation	(Month, Day 1 Sary		,	Yes 2 □ No				
<u> </u>	I or Attend after death Director: /	rtiffe	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, /)	street, factory, office		28f. Location (Stre City or Town,	eet and Numb State)	er or Rura	l Route Number,
	pital		29a. Certifier X Certifying Phy	sicien: To the best of my know	wladna d	eath occurred at the tim	e date and place	and due to the car	use(s) and ma	nnor on st	ntad
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Medical Exem	iner: On the basis of examinal and manner stated.	tion and/o	r investigation, in my op	pinion, death occurr	ed at the time, da	te and place, a	and due to	the cause(s)
	To the Hospital of within 24 hours all To the Funerel D completely filled i	Me	29b. Signature and title of certifier	T.Q. M	7	29c. License	number	29	d. Date signed	(Month, L	Day, Year)
	/		1 cmil	h Jow III	V.	D 24	034		1141	04	
	h		30. Name and address of person who c	ompleted cause of death (Item	23a) (Ty	pe, Print)			1 1		
			TIMOTHY LOW. M. 31. Date filed (Month, Day, Year)	D. 76 Ø11 OS	LER	DRIVE TO	WSON, M	ARYLAND	2120	4	
	Sta Registr		NOV 0.9 2004	32. Registrar's Signa	here						

State of Maryland / Department of Health and Mental Hygiene 35407 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month PATRICIA LEWIS AGNES NOV 2004 /Medical 4:10 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🔀 F 187-34-7747 63 1940 Pennsylvania Director Usual Residence of Decedent with the Maryland ?7 is marked other then "natural", or liems 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges 1 ☐ Yes 2X No Directo Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11909 Gordon Avenue 20705 UŞA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If item 27 is marked other then "natural", or ite, any injury or other traumatic event, the Medical Examina. ☐Yes 2☐XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ If Yes, G., Year or Dates: Specify: White 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George M. Enright 2 Betty Kovalusky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane S. Robbins / Friend 11909 Gordon Avenue Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Metro Crematoru Inc. 11/06/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician NON-HODGKINS LYMPHOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transil and resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 X No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) noncon November 521 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 MICHAEL MONSOUR LCDR MC USN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2004 Registrar

			1 - For State Registrar	State of Maryland / Dep.	artment of Health and artificate of Death	Mental Hygie	
	Physici	an	1. Decedent's Name (First, Middle, Las			2. Date of Death	Day Year 3. Time of Death
	/Medi	cal	MARY JOANN L			NOVEMBER	1, 2004 11:28a M
1	Examir	ıer	4a. Facility Name (If not institution, give 6625 WHITESBURG RO		4b. City, Town, or Location of Dea SNOW HILL	th	4c. County of Death WORCESTER
	Funeral Director		5. Social Security Number 217-42-5932 Usual Residence of Decedent	9x □ M 2 F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country)
	ryland how		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	with the Maryland a or 28a-f show the rectified at	Director	MD WORCE	STER BERL	LIN		1 ¥Yes 2 No
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examiner must be realised at	i Dir	3/8/1/FST ST		10f. Zip Code	10g.	Citizen of What Country?
	ter death w items 23a	Funerai I	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
920	ours after or iter	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 No Specify:	,,	Specify: WITE
5-0	72 hours "natural",	eted	15. Decedent's Ed (Specify only highest grad	ucation 16a. Dece	dent's Usual Occupation	dking 16b	. Kind of Business/Industry
121	d within 72 ho piene. r than "natur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of wo DO NOT use retired)	山	XATALITA
nd 2	be filed tal Hygid d other avent, L	Be C	17. Father's Name (First, Middle, Last)	- WA		me (First, Middle, Maid	den Sumame)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic avent. The Monce.	To	JOSEPH LUTZ		HELENA	JEAN MA	RTIN
	od 2 sh lth and 27 is rr r traum	1	19a. Informant's Name/Relationship (T	ype, Print) 19b. Mailli AUGHTER 437	ng Address (Street and Number o. Ri	Iral Route Number, Cit	ty or Town, State, Zip Code)
Jre,	of Hea		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	ment tant: it jury o		1 ☐ Burial 2 ☑ Cremation 3 ☐ I 1 4 ☐ Donation 5 ☐ Other (Specify,	BAYVIEW	A	5-04 BA	LTIMORE MD.
Ba	permit. Departr Imports any inju		21. Signature of Fune al Service Licens	22	 Name and Address of Facility Daugherty Family Funeral H 	ome And Cremation	Center, P.A.
			23a. Part1. Enter the disease, of comp shock, or heart failure. List only of	lications that caused the death. Do not ent	2601 Mountain Road ter the mode of dying, such as cardia	 Pasadena, MD. or respiratory arrest, 	21122 Approximate Interval Between
	Pnysician .		Immediate Cause (Final disease or condition	· Antonosumono	CAGDIOVASCIM	n Duen	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequence of).			
	and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
68760,	ficate be executed physician and s the burial-transit	edical E		d			
	*= O 66	Medi	IF FEMALE:	·			
). Box	s death certifi he attending p ed for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.0	requires that the de een signed by the a nould be detached f		9 ☐ Unknown Part II. Other significant conditions co	ntributing to death but not resulting in the ur	nderlying cause given in Part I	23e. Did tobacc	o use contribute to the cause of death?
Division of Vital Records,	w requires been sign should be	Completed by	CIRMHOSIS OF				2 No 3 Probably 4 Monknown
eco	~ 0 75	plet				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a R	sician: The law certificate has l irector, page 2 s					performed?	death2
Z.	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? ★XXYes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	l Out	th (Check only one)	
n of	ng Phy ter this neral c		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		ome 5 Residence 28d. Describe how in	
isio	Attanding r death. sctor: After by the funer	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No		
DIV	al or A	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, streed building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ute)
	To the Hospital or Attanding Physician: whithin 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Phy Medical Exemi	sicien: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	melycyle my	29c. License number OCME		Date signed (Month, Day, Year) VEMBER 2, 2004
- 1							
ľ	h	Ţ	1 1 1 1 1 1 1 1	empleted cause of death (Item 23a) (Type, I			
ľ) Sta	e	30. Name and addres of person who co	1 :1 . 0 -	11 Penn Street, B	altimore, M	Maryland 21201

)	Please	State of Mary						gible.	
			1 - State Registrar	Otato of Mary		ertificate of		wientai riy	Reg. No.	104	35409
	Dhysia		1. Decedent's Name (First, Middle, L	ast)				2. Date of D	eath		3. Time of Death
	Physic /Medi		LYUDMIL			LISITSA		Novemb	lez 3	200 4	11:15 AM
	Examir	ner	4a. Facility Name (If not institution, girls Sina Heapital 5. Social Security Number 6.	of Baltim		Baltin		ty		unty of Death	N/A
ŀ.	Funeral Director			Sex 7. Age (In	yrs. last birthday 51 Yrs.) If Under 1 Year Months Days	If Under 24 Hr Hours Mir		^{rth} ,1953	9. Birth Cou	place (State or Foreigr INTRAINE
	ryland how		10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside City Limits
	8a-f	ecto		BALTIMORE	OWIN	IGS MILLS					1 ☐ Yes 2 🔀 No
	with the	D	10e. Street and Number			10f. Zip Code	21117		10g. Citizen	of What Cou	ntry? UKRAINE
	death ms 23	era	9 RACHEL COURT 11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I		Specify Yes or No	p- 14, I	Race - Ameri	
900	filed within 72 hours after death with the Maryland Hygiene uther then "natural", or items 23e or 28a-1 ehow ont, the Modical Examinar must be notified at	d by Funeral Director	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 💢 No		rto Rican, etc.)		Black, White, ecify:	
5-("natur	etec	15. Decedent's 8 (Specify only highest g	ducation ade completed)	16a. Dece (Give	edent's Usual Occup kind of work done DO NOT use retire	oation during most of we	orking	16b. Kind o	f Business/In	ndustry
Maryland 21215-0036	s 1 and 2 should be filed withir f Health and Mental Hygiene. item 27 ie marked other then other traumatic event, Ite M.	Completed	Elementary/Secondary (0-12)	4 College (1-4or 5+)		STYLIST				SALON	
and	intal H ed ot	Be c	17. Father's Name (First, Middle, Las SAMUEL	t)	GERSH	ITETN!	18. Mother's Na	ıme (First, Middle	, Maiden Sun	name)	VAYS
aryl	should I	2	19a, Informant's Name/Relationship	(Type, Print)		ing Address (Street		ural Route Numb	er. City or To	wn. State Zio	
	다 25 분리		PAVEL LISITSA /	HUSBAND		HEL COUR					, 0000,
Baltimore,	00		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from State		matory or other pla		Date		on - City or To	
Itim	permit. Pag Department Important: I any injury o		 4 ☐ Donation 5 ☐ Other (Spec. 21. Signature of Funeral Service Lice 			CHIZUK A				LTIMOR	
Ba	permit. Departrimports any inju	1	Edward C.	Rent		2. Name and Addre					
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	one cause on each line.	s toma	multif		correspiratory a	mest,		Approximate Interval Between Onset and Death
60,	be executed iician and burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a con	sequence of):						
687	physical phy	dlca		d.					_		
.O. Box (death certif e attending id for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 I 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		/ /	Date of delive	ery Day Year
<u>α</u>	g B B		Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to th	ne cause of death?
rds	w requires been sign should be	Completed by						1 🗆 '	∕es 2□No	3 🗆 Prob	ably 4⊠Unknown
Vital Records,	law re as be	plet						24a. Was	an 24	b. Were auto	psy findings available
<u>~</u>	ian: The I rtificate ha tor, page	Corr						perfo	rmed? 2 No	death?	npletion of cause of 2 🕰 No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only o			
of): To	1 ☐ Yes 2 🕱 No 27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	nt 3□ DOA Out	4 ☐ Nursing F	fome 5 Resid			1)
ion	Attending in death. ctor: After by the funer	atloi	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation		r) Injury	Wor	k? Yes 2⊡No		,.,		
Division	i gig e	Certification:	3 Suicide 6 Could not to determined		At home, farm, str ecify)	eet, factory, office		28f. Location (S City or Tox	Street and Num m, State)	mber or Rura	l Route Number,
	Mospital 24 hours a Funeral I etely filled	Medical (29a. Certifier Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	a, and due to the ourred at the time,	ause(s) and late and place	manner as st e, and due to	ated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date sign	ned (Month, I	Day, Year)
•			K. A. Zamar	r, M.D.		RE	5-000	,	Nove	uber	3,2004
	3		30. Name and address of person who KAZI A. ZAMA		Item 23a) (Type, SiNAI	Print) HOSPITA	L OF	BALTIM			
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0.9 200.	22. Registrar's Si	ignature	S. s					

			1 - For State Registrar	State of Mar		artment of <i>rtificate o</i>		-	giene	4 3541	n
	Physic /Medi		1. Decedent's Name (First, Middle, Las Flore	nce Mulle	n			2. Date of De Month	8, Day 2002	3. Time of Death 7:00a	n M
	Exami	ner	4a. Facility Name (If not institution, give Rock Glen Nursing 5. Social Security Number 6. Se	& Rehab. C	enter (In yrs. last birthday)	Balt	o, or Location of Dea Limore ar If Under 24 Hrs		4c. County o		
	Funeral Director		216-76-3361 Usual Residence of Decedent	V_	87 Yrs.	Months Day		8. Date of Bir Month, Da JUL 10		9. Birthplace (State or Fore Country) 1assachusetts	iign }
	with the Maryland is or 28a-f show Lbs notified at	ctor	10a. State 10b. County Maryland Howard	1	IOc. City, Town or Lo	Mt. Ai	ry			10d. Inside City Lim 1 ☐ Yes 2√1	
	ath with the s 23e or 2	Funeral Director	914 East Waters	-		10f. Zip Code	21771		10g. Citizen of Wi USA	,	
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importent: If item 27 ie marked other than "naturel", or items 23e or 28a-1 show any hipportent: If item 27 ie marked other than "naturel", or items 23e or 28a-1 show any hipliny or other traumatic svent, the M-dical Exarts for must be notified at any hipliny or other traumatic svent, the M-dical Exarts for must be notified at any once.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I	Was Decedent of the Yes, specify Co	f Hispanic Origin? (suban, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Black, Specify:	- American Indian, , White, etc. White	
21215-0036	filed within 72 h Hygiene. Ither than "natu Ith Mydica	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti nemaker	ne during most of wa	rking	16b. Kind of Busi	,	
Maryland	ould be file Mental Hy tarked oth	To Be (17. Father's Name (First, Middle, Last) William E. W				Flor	ence Ray			
	1 and 2 sh Health and em 27 ie m ither traum		19a. Informant's Name/Relationship (T. Jon James Nairns/		914	East Wat	et and Number or Ri ersville	Road Mt	or, City or Town, St		
Baltimore,	permit. Pages. Department of H Importent: If ite any injury or ot		20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 □ I 1 □ Donation 5 □ Other (Specify,		Metro Cre	ematory or other p	_Inc. 11/		20c. Location · Ci	re, MD	
Ba	Departrice Departrice Imports any injuice.		21. Signature of Funeral Service Licens Dawn F McDon	ald		299 Fred	ns Society erick Roa	d Balti	more, MD	c. 21228	
	Physician /Medical Examiner	ı	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentiatly list conditions,	a. A THERE Due to (or as a c	onsequence of):					Approximate Interval Between Onset and Death	S
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c Due to (or as a c	,						
P.O. Box 6	death certifi e attending p od for use as	Physician/Mec	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	l3c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnani Other (specify)	су		23d. Date of Month	*	
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co.	ntributing to death but n	ot resulting in the ur	derlying cause g	iven in Part I.	23e. Did to	.	ute to the cause of death?	'n
	The ate h page	Completed						24a. Was a autops perfor 1 Yes	sy prio med? dea	re autopsy findings availabler to completion of cause of th? Yes 2 \(\subseteq \) No	le
	Attending Physicien: I r death. ector: After this certifical by the funeral director, p	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	28c. Inju	ther: 4K Nursing H		ence 6 Other ((Specify)	
-=	el or Atten s after deat sl Director: ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury building, etc. (5	- At home, farm, stre Specify)	et, factory, office		28f. Location (Si City or Town	reet and Number on, State)	or Rural Route Number,	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Examination	sicien: To the best of maner: On the basis of example and manner stated	amination and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occu	, and due to the corred at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)	
	To the To the Complet	M	29b. Signature and title of certifier	Cul	W BO		se number		9d. Date signed (A		
	P			MACKECKL	0,40 5	Print) Y// OLD		R.CK K	21229		
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Spa					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. Place of Maryland Department of Health and Mental Hygier (1) [1] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 9:00 a^M Milus Edgar Mills, Jr. 2004 Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beltsville 3128 Christine Drive Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 7, 19 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 87 Yrs 578-18-5646 Director 1917 Alabama Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No MD Prince Georges Director Beltsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3128 Christine Drive 20705 Funerai USA death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 □XXXs 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ white 3 Widowed 4 XXXX rced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, Tre Meuis 2006. Elementary/Secondary (0-12) College (1-4or 5+) executive government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Mayfield Milus E. Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) caregiver 3128Christine Dr. Beltsville, MD. 20705 Anna King Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Chesapeake Crematory 1 ☐ Burial 2 🕱 🛪 emation 3 ☐ Removal from State 11/5/04 Beltsville * 4 □ Donation 5 □ Other (Specify) , MD 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility 933 Gist Ave. Silver Spring MD. 20910 Enter the disease, Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Metastatic Prostate Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) attending physician Completed by Physician/Medical as 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 TUnknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 nknown peeu 24a. Was an autopsy performed?
1 ☐ Yes 2 ♣ No 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 2□ No 1 TYes Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home \$\infty \text{Residence} 6 Other (Specify) Hospital: 1 ☐ Yes 2√XX 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Diractor: After 5 Pending investigation 1 Naturat 1 Yes 2 No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, completely filled in by the funeral within 24 hours a Hospital To the

> DY State Registrar

Dr. Edward Mosley 31. Date filed (Month, Day, Year) NOV 0 9 2004

29b. Signature and title of certifier

3128

ddress of per en who completed cause of death frem 3a) (Type, Print)

32. Registrar's Signature 20 pe

Christine Drive, Beltsville, MD

29c. License number

29d. Date signed (Month, Day, Year)

			1- State of Maryland / Registrar	Depa Cer	artment of H tificate of L	lealth and I Death		giene Reg. No	. 009	35412
	Physicia		1. Decedent's Name (First, Middle, Last) Merl David Myers				2. Date of De Month Novembe	Day	5 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Laurel Regional Medical Center		4b. City, Town, or Laure1	Location of Deat	h	4c.	County of Dea	ath
Ī	Funeral Director		5. Social Security Number 219−18−8010	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 11	th v. Year)	9. Bi	rthplace (State or Foreign
	B Maryland	ctor	Usual Residence of Decedent 10a. State	wn or Lo Lau	_					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with th	al Director	10e. Street and Number 16111 Julie Lane		10f. Zip Code 20707			10g. Cit US.	izen of What C A	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. The propriete if the most and there than "netural", or itams 23a or 28a-f show morth in the most propriete any Injury or other treumatic event, the Marical Examinal remaints any illied at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣 No	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Am Black, Wh Specify: W	ite, etc.
21215-0036	nin 72 ho n "netul wed cel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired	during most of wor	rking		ind of Busines	
7170	filed with Hygiene other the	e Com	17. Father's Name (First, Middle, Last)	suj	pervisor	18. Mother's Nar	ne (First, Middle,		ational	rehab
yland	nould be if Mental narked c	To Be	Charles S. Myers	01. 14. 11.			a Tusing		-	7.0.11
, Mar	es 1 and 2 sh of Health and I Item 27 is m r other treum		Lillie R. Myers (spouse)	1611	g Address (Street a l Julie L		e1, Md 2			Zip Code)
Baitimore,	ages 1 ent of He nt: If Iten y or oth		1 Burial 2 Cremation 3 Removal from State	tery, cren	sition (Name of natory or other plac y Cremati	· 1	2-04		esville	
Baltil	permit. F Departme Importer any Injur		21. Signature of Funeral Service Licensee Paige Haight Service	22	Name and Address O. Box 1	ss of Facility Ha	ight Fur	nera:	1 Home	
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final							Approximate Interval Between Onset and Death
	Fn ysician /Medical Examiner		disease or condition resulting in death) a. <u>Ventricular and Due to (or as a consequence</u>	e of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Final Indexing. Due to (or as a consequence cause. Final Indexing.)	e of):						5 yrs
,	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last advanced arthe	e of):						15 years
94/60		dlcal	hypertension a	and a	aortic va	lve dise	ase			20 years
O. Box	w requires that the death certifi been signed by the attending should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)				23d. Date of de Month	olivery Day Year
ς, σ.	law requires that the as been signed by th 2 should be detache	by	Part II. Dther significent conditions contributing to death but not resulting diabetes mellitus	j in the ur	nderlying cause give	en in Part I.		obacco u Yes 2]		o the cause of death?
II Kecord	The farate has	Completed					24a. Was autor perfo 1 🗆 Yes		prior to	utopsy findings available completion of cause of
Vital	S 77	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☒ ER/C	Dutpatien	t 3 DOA		th <i>(Check only o</i> lome 5 ☐ Resid		6 □Other (Spe	əcify)
lon of	After Arter	atlon: T	1 X Natural 5 Pending (Month, Day Year) 2 Accident investigation	. Time of Injury	Work		28d. Describe h			
Division	el or Attences after death	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Pface of Injury - At home, building, etc. (Specify)	larm, str	eet, factory, office		281. Location (S City or Tox	Street an vn, State	d Number or Fi)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowled 2 Medicel Exeminer: On the basis of examination a and manner stayed.	ge, death and/or inv	occurred at the tim restigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the To the comp	M	29b. Signature and title occurring		29c. License D1367			29d. Dat 1–07	e signed (Mon 7-04	th, Day, Year)
	10		30 Name and address of person who completed cause of death (Item 23a B.G. Manejwala, M.S. 14201 Laure)	l Pai	ck Dr., L	aurel, M	D 20707			
b	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2004	A	bake					

		State of Maryland / Depar 1- State Regist/AMEND TTEM #20b PER IN G837 15/15	tment of Health and M		ne 004	35413
Physici		1. Decedent's Name (First, Middle, Last) Shawn Mark Montague	704 311	2. Date of Death Month Oct 24,	Day Year 2004	3. Time of Death 6:30 P M
/Medio Examir	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death LaP1ata	000_24,	4c. County of Death Charles	
Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 27,	ear) 9. Birth Cou 1967 Mar	place (State or Foreigr intry) Cyland
2 hours after death with the Maryland 2 hours after 338 or 28e-1 show eture!; or items 238 or 28e-1 show	Funeral Director	10a. State 10b. County 10c. City, Town or Local CHARLES Indian 10e. Street and Number 5001 Nelson Point Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Warmed Forces?	Head 10f. Zip Code 20640 as Decedent of Hispanic Origin? (Speres, specify Cuban, Mexican, Puerto		Citizen of What Cou United 14. Race - Amer Black, White	States
other then "neture", cent, the Medical Exc.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kiii life. DC) Mechan		ing	B1ac Black Black Business/II	
yidi ould bo Menta Menta marked	To Be	Jeremiah James Montague , Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing		e (First, Middle, Ma. a Waiters		in Code)
Dattillior, Mary permit. Pages 1 and 2 shd Department of Health and Importent: If item 27 is m any injury or other traum once.	1 1	Carlos M. Montague (Brother) 7570 S 20a. Method of Disposition 1 Daurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposit cemetery, crema Lincoln Me	hirley Blvd., Portion (Name of tory or other place) Oct 30, morial Cemetery Name and Address of Facility Lee	rt Tobacc 2004 S Funeral	o, MD 2067 c.Location - City or T uitland, M Home, Inc	77 own, State faryland 5633 Old
certificate be executed Certificate be executed by the executed b	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentiary let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	exandria Ferry Ro			Approximate Interval Between Onset and Death
death certific	ysician/Med		ctopic pregnancy Other (specify)		23d. Date of deliv	rery Day Year
VICAL TEO /sicien: The laves scertificate has director, page 2	To Be Completed by Physi	Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions conditions contributing the significant conditions	ere, aremes rangement. 26. Place of Death	24a. Was an autopsy performed 1 Yes 2 (Check only one)	24b. Were auto prior to co death?	bably 4 Unknown opsy findings available impletion of cause of 2 No
ng ng the	ertification:	27. Manner of Death 15 latural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, stree building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stree City or Town, S	it and Number or Run	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t.	Medical C	29a. Certifier (Check only one) 12 **Certifying Physician: To the best of my knowledge, death of Medical Examiner: On the basis of examination and/or investand manner stated. 29b. Signature and fate of certifier	29c. License number	ed at the time, date	e(s) and manner as s and place, and due t Date signed (Month,	o the cause(s)
Sta Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Paul E. Pritchett, MD 118 LaGrange Av 31. Date filed (Month, Day, Year) 32. Registrar's Signature		LaPlata, 1	MD 20646	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVENBER 4, 2004 **Physician** PHILLIP MARCHANTI 2:45 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CONTINUING CARE NURSING HOME SYKESVILLE CARROLL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year)
DEC. 19, 1918 Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F Hours 212-01-5734 85 Yrs Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD 1 Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6429-A ELRAY DRIVE 21209 or items 23e USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after of Hygiene.

At Hygiene.

other then "naturel; or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ARMY 1 ☐ Yes 2X No þ Specify WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER 0IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tent: If item 27 is marked otl Be MARCHANTI OLIVER. MAMIF (UNKNOWN) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOEL MARCHANTI / SON 6429-A ELRAY DRIVE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: if ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) (ANSHE EMUNAH)AITZ CHAIM 11/7/2004 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) etra ton /Medical Due to (or as a consequence of) tactive Palmoray Visease Examiner Sequentially list conditions, it any, leading to infinite liate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ icate has been sig , page 2 should b 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? certificate 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onlone examiner? Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident 5 Pending death. investigation 1 Yes 2 No Director: / 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ano V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 9 2004

			For Stata Registrar		State	e of Ma	arylan	d / Dep <i>Ce</i>	artmen <i>rtificat</i>	t of H e of L	ealth a Death	and M	lental Hy	giene Reg. No.) L	354	15
	Dhysiair		1. Decedent's Name	e (First, Middle	, Last)								2. Date of De Month	eath Day	/	Year	3. Time	of Death
	Physicia /Medic		Frederic				Sr.						Novemb	er 6	, 20	004	8:55	a ^M
	Examin	er	4a. Facility Name (If						4b. City,		Location of					of Death		
-			Gilchrist 5. Social Security N		f for H			lre last birthday	If Under		OWSOT		9 Date of Bi		lti		ala a a (Casa)	Foreign
	Funeral Director		217-40-40		1)X M 2□			61 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Da Jun 28	ay, Year)	43	Cou	place (State ntry) Land	or Foreign
			Usual Residence of										oun zo	, 10	15	TIGE Y	Tand	
	yland	. [10a. State	10b. County			10c. Cit	y, Town or L	ocation								10d. Inside	
	e Ma	cto	MD	Baltin	nore		Ess	ex									1 ∐ Ye	s 2 No
	or 21	Director	10e. Street and Nun	nber					10f. Zip					_		What Cou		
	s 23a	ra	10 Cardin	al Lane		D41		5 42	212			-:-0 (0-				Stat		
	Item Item	Funeral	11. Marital Status 1 Never Marri	ed 2⊡ Marri	Arme	Decedent B d Forces? es 2 0 0 s, Give	ever in U				n, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	0-		k, White,	can Indian, øtc.	
336	al', or	by	3 Widowed	1/	If Yes Year	or Dates:			1 🗆 Yes	No	Specify:				Specify	/: White	2	
9	r2 hor	Completed	/Snan	15. Decedent	's Education t grade comple	taril		16a. Dece	dent's Usua kind of wo	I Occupa	ation	t of work	ina	16b. Ki		usin <i>e</i> ss/In		
21	thin 7	npie	Elementary/Secon		T	ge (1-4or 5	+)	life.	DO NOT u	e retired)	. 0, 110,11	9	Balt	imo	re C	ounty	
21	lygier her th	S	11	/Fire Adiabate 1	l and l			Equip	ment	Oper		da Nam	- /Cinca Adiaballa	Administra	Curana)		
and	ntal Hed ot	Be	17. Father's Name (Dorot		First, Middle Gonder		Surnam	10)		
Š	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examinar must be notified at	2	19a. Informant's Na)		19h Maili	ng Address	(Street a			al Route Numb		r Town	State Zir	Code)	
Z	and 2 s ealth an n 27 is		Donna J.						•				rkville				,	
ē,	s 1 ar f Hea item other		20a. Method of Disp	position			20b. F	lace of Disperentery, cre				-	Date				own, State	
e e	Pages nent of I int: If its iry or o		1 ☐ Burial 2) 1 ☐ Donation		3 □Removal f secify)	rom State	1	esapea			1		ov 10 004	Belt	svi	lle,	MD	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Fu	neral Service L	icensee //	1	100%	X(0 2	2. Name ar	d Addres	s of Facilit	y Fune	ral Alt	terna	a + i xz	6 5		
m	20 = 3		126	14	alel		1000						s Drive				, MD	
			23a. Part1. Enter the shock, or hea	he disease, or rt failure. List (complications to only one cause	hat caused on each lin	the deat ne.	h. Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory a	irrest,			Approxima Interval Be	etween
	Physician		Immediate Cause (disease or conditio	(Final In	_ a	PLVI	The	sal	Jasc	ula	2 d	110	use				Onset and	-5
	/Medical Examiner		resulting in death)		Du	to (or as	a conseq	uence of):									(
		<u></u>	Sequentially list con if any, leading to im	nditions,	b. —	e to (or as	a conseq	uence of):								-		
	uted 1 ansit	Examiner	Cause (Disease or	riying injury														
ALC.	cate be executed oblysician and the burial-transit	Еха	that initiated events resulting in death) I	Last	C. Du	e to (or as	a conseq	uence of):										
8760,	cate be ohysicia the bur	dicai			d													
9	ntifica ng ph s as th	Med	IF FEMALE:											T				
Вох	death certifica attending ph I for use as th	lan/l	23b. Was decedent		1 🗆 L	ive birth	2 Feta	death 3	⊒Ectopic pi						23d. Dat Moi	e of deliventh	θry Day	Year
0.	the a	Physician/Med	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No		Prøgnant at Jnknown	time of d	eath 5(Other (sp	ecify)								
σ.	that the death cer ed by the attendin detached for use		Part II. Other signif	icant conditio	ns contributing	to death bu	ut not res	ulting in the u	ınderlying d	ause give	n in Part I		23e. Qid	tobacco u	se conti	ribute to t	he cause of	death?
ds	ulres that signed I	d by											1)(2)	Yes 2	□No	3 Prob	bably 4	Unknown
00	w requir s been si should	Completed											24a. Was		24b. \	Were auto	opsy findings	s available
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ital	an: rtifica tor, p	a	25. Was case refer	red to medical							26. Place	of Deat	h (Check only	/-		103	20110	
>	nyaici nis ce I direc	To B	examiner? 1 ☐ Yes 2	No	Hospital:	1 🗌 Inpatie	nt 2 🗆	ER/Outpatie	nt 3 DC	Othe	ar: 4 🗆 Nu	irsing Ho	me 5 🗆 Resi	idence (oth.	er (Specit	4) 203/	914
0 0	ng Pł liter tł uneral		27. Manner of Deat	h 5 ☐ Pending	28a. [Date of Injui Month, Day	y Year)	28b. Time of Injury		8c. Injury Work	:?		28d. Describe	how injur	y occurr	ed	A 45-41-11-11-11-1	
sio	tendi leath. tor: A the fu	cati	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could r	ot bo	N	44 h		M		res 2 🗌	- 1	ORE Lanction	/Cara - 4 a -	and Advanced to		10-1-1	
Division of Vital Records, P.O.	or At after d Direct in by	Certification:	4 Homicide	determi	ined 28 <i>8</i> . I	ouilding, etc	ury - At hi c. (Specif	ome, farm, st	reet, factor	, office			28f. Location (City or To	wn, State	a Numbi	er or Hura	u Houte Nui	mber,
	e Hospital or Attending F 24 hours after death. a Funeral Director: After etely filled in by the funer.		29a. Certifier	Certifyin	g Physician: T	o the best	of my kno	wledge, deal	th occurred	at the tim	ie, date an	d place.	and due to the	cause(s)	and ma	nner as s	tated.	
	To the Hospital or Attending Phyaician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Medical	(Check only one)	(2 Medical f	Examiner: On t	the basis of manner sta	examina	tion and/or in	nvestigation	in my of	oinion, dea	th occur	red at the time,	date and	place, a	and due to	the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier	1. 1					License		-		29d. Dat	e signed	(Month,	Day, Year)	201
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	13		31. Date filed (Mon	W V	011	32. Registra			011	v. (nate	3 01	1791	cons	- 1	110		
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DHMH 17 Rev 1/2001

Amend item#10e, per Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Julia Roberta O'Wesney Nov. 5, 3:35 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13801 York Road H9 Cockeysville Baltimore 8. Date of Birth (Month, Day, Year) April 17,1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 1□M 2X F 219-18-6956 80 Yrs. Director PΆ Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State is 1 and 2 should be illed within 72 hours efter deeth with the Marylan of Heelth and Mentai Hygiene. Item 27 is marked other then "netural", or iteme 23a or 28e-f show other treumatic event, the Medical Examinational perioditied at 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Baltimore Cockeysville 10e. Street and Number 13801 York Road H9 10f. Zio Code 10g. Citizen of What Country? 119 13801 Work Road 21030 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ፩ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed ovember 5,2004 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Regional Supervisor State of MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert M. O'Wesney ပ Julia Fleming Peges 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Young/Nephew 16 Meran Dr. Henderson, NV 89074 20b. Place of Disposition (Name of cometer, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Nov. 8, 20c. Location - City or Town, State permit. Peges
Depertment of
Important: If it
eny Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Timonium, MD 21. Signature of Funeral, Ser 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part - Enfer the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent ice of Examine ettending physicien and for use es the buriel-transit certificate be exe Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e of Vital Records, P.O. 9☐ Unknown 9 Unknown Lio K. Owenti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ page 2 should be 2 No Completed 3 Probably 4 □Unknown 1 ☐ Yes After this certificete hes been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes funeral director. 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Natural 2 ☐ Accident Injury deeth. Director: / 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours elements To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) mare) 30. In and address of pe who completed cause of death (Item 23a) (Type, Print) Dr. Francis Sanzaro, M.D. 13801 York Road Cockeysville, MD 21030 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV Q 9 2004 Registrar Spark

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death North Day Eileen **Physician** earre /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howa County HOSD General Colimbia Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Director 1947 Maryland 219-50-4542 June 19 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 3211 Little Patuxent Parkway USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Mudical Examiner: 1 ☐ Yes 2 ☐ If Yes, Give 2 Year or Dates: 1 Never Married 2 ☐ Married 2 TNO Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: White ۵ Specify 3 - Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene. If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary Retail Store other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Pearre ပ Phyllis Norfolk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Treuth Jr. / Son 103 Hillside Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Important: If Iten
any injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Inc. 11/05/04 Baltimore, Maryland Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespiratory Physician allers /Medical Due to (or as a cons-quence of): Examiner nemond Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner obstrulue anney disease burial-transit The law requires that the death certificate be executed ellen and Due to (or as a consequence of): Box 68760, physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the a be detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably page 2 should 1 ☐ Yes 2 ☐ No 4 🗍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No : After this certifica e funeral director, r To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) P Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) illed in by within 24 hours after To the Funeral Direct 4 - Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 4th 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clarksulle Bell Lane 4bdo, MD 5005 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** November 6, 2004 1:15 AM M Howard Henry Patton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mt. Airy Carroll 5119 Fleming Road If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F 238-24-0993 81 Director 11, 1922 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Sykesville Directo Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5051 South Klee Mill Road United States 21784 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than any injury or other traumatic event, tra Means of sones. Elementary/Secondary (0-12) College (1-4or 5+) 12th Home Builder Patton Contractors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Patton Mimmi Candill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nell Jones Patton Wife 10 Venture Way Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Nov. 11, 2004 Lansing, North Carolina Lansing Meth. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Imme ate Cause (Final diser e or condition ulting in death) Onset and Death Physician Conjective one year /Medical Due to (or as a const uence of): Examiner Pul hund Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physiclan/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by ti d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 🗆 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4\square}$ Nursing Home $_{5\square}$ Residence $_{6}$ Nother (Specify) Sons Home 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4, 2004 PF172000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 106 Ewerson am iTAS TIOS 1380 Progress Way MUD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 9 2004

			1 - For State Registrar	State of M	aryland / Dep	artment ertificate			ind Mer		iena _{eg. No.} (004	35419
	Physic		1. Decedent's Name (First, Middle, La ARLENE	st)		R	0SE			Date of Deat	h Day 5	2004	3. Time of Death 6:45 P M
	/Medi Examir		4a. Facility Name (If not institution, giv	CENTER		4b. City, To	INS	TER			4c. Co	unty of Death	
	Funeral Director		5. Social Security Number 108-28-3574 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. last birthda 70 Yrs.		Year Days	If Under 2 Hours		Date of Birth	34"	9. Birth Cou	place (State or Foreign ntry) N.Y.
	aryland show	_	10a. State 10b. County		10c. City, Town or								10d. Inside City Limits
	r 28a-f	Funeral Director	MD CARROLL 10e. Street and Number		WESTMIN:	10f. Zip C	ode	-		10	0g. Citizer	of What Cou	1 ☐ Yes 2 X No
	s 23a o	rai D	4206 TEKLEN DRIV			211						U.S.A	
980	within 72 hours after death with the Maryland nne. than "natural", or Items 23a or 28a-f show he Madical Exerciter; wat be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Deceder If Yes, specify 1 \sum Yes 2	,	spanic Orig n, Mexican Specify:	in? (Specify , Puerto Rica	Yes or No- an, etc.)		Race - Ameri Black, White, WH] ecify:	can Indian, etc. [TE
Baltimore, Maryland 21215-0036		Completed	15. Decedent's E. (Specify only highest grant Elementary/Secondary (0-12)	ducation ade <i>completed</i>) College (1-4or	(Gir (S+)	edent's Usual (re kind of work DO NOT use	done di	uring most	of working			of Business/Ir HOME	ndustry
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Mary	2 2 20 2	F	19a. Informant's Name/Relationship (**	19b. Ma	ling Address (S		nd Numbe	r or Rural Ro		,	own, State, Zip	
re, 1	an eal eal n 2		JERRY ROSE / HUSI		20b. Place of Dis	TEKLEN position (Name amatory or othe			ESIMII Date			ion - City or T	own, State
timo	permit. Pages 1 Department of H Important: If iten any injury or oth once.		1 ⚠ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif	(y)	BETH SHA	_OM		1				SVILLE	
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licer	1500		22. Name and A							MD 21208
	Physician		23a. Part1. Enjer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	47.4	the death. Do not end.			, such as c	cardiac or re	spiratory arre	est,		Approximate Interval Between Onset and Death
E	/Medical Examiner			Due to (or as	a consequence of):								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to (or as	a consequence of):								
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):								
9	artificate Ing physie as the t	Medic	IF FEMALE:	_ d.									
.O. Box	the the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic preg □ Other (spec					23d.	Date of delive Month	ery Day Year
ords, P	w requires that i been signed by should be deta	by	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cau	se givei	n in Part I.		23e. Did tob	\		ne cause of death?
Vital Records,	The law ate has b page 2 sl	Completed								24a. Was an autopsy perform 1 Yes 2	red?	prior to co death?	psy findings available mpletion of cause of 2 No
f Vit	ysic is ce direc	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🗹 Inpatie	ent 2 ER/Outpati	ent 3 DOA	Other			neck only one 5 🗌 Resider		Other (Specif	y)
on of	ding h. After fune		27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	of 28c	Injury Work	at	28d.	Describe how			
Division	after death. Director: After in by the fune	ertification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm, s c. (Specify)				28f.	Location (Stre City or Town,	eet and Ni State)	umber or Rura	l Route Number,
	Hospita 4 hours Funeral ely filler	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	examination and/or	th occurred at investigation, in	the time my opi	e, date and inion, death	place, and	due to the car t the time, da	use(s) and te and pla	l manner as si ce, and due to	tated. the cause(s)
)	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	k. Gal	Uca 111	29c. L	-	number	0	29	d. Date si	gned (Month,	Day, Year)
	10		30. Name and address of person who	CALVW	eath (Item 23a) (Type	Print)	Ne	28	tuenu	ولن	Sm	INSTE	ic mandas
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 9 200	2. Registr	ar's Signature		-						

		1 - For State Regardent 1	State of Ma	ryland	I / Depa	artment of F	lealth and N Death		ene 0 ()4	35420
		Decedent's Name (First, Middle, La	St)	303/	11/09	/U4-JH		2. Date of Death	1	V	3. Time of Death
Physicia /Medic		BERNAR	D			REICHMAN		November	Day 5 2	Year 004	4:05 A M
Examin	er	4a. Fecility Name (If not institution, giv				-	r Location of Death	1	4c. County		
Funeral	2	Greater Baltimore 5. Social Security Number 6. S	Sex 7. Age		st birthday)	Tows If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		1timo	
Director		107-12-3557	X M 2 F	85	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, MAR.15,	1919	Cou	place (State or Foreign ntry) PA
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
h the Maryland or 28a-f show	tor	MD B.	ALTIMORE		LUTH	ERVILLE					1 ☐ Yes 2 ☑ No
death with the Maryland ms 23a or 28a-f show traust be notified at	Funeral Director	10e. Street and Number				10f. Zip Code			g. Citizen of V	Vhat Cou	•
agth w	erall	8 CANDLESTICK DR		i= 11.0	140.1	V- D	21-03 21		44.0		USA
fler de	Fune	11. Marital Status 1 ☐ Never Married 2 🛣 Married	12. Was Decedent E Armed Forces? 1 M Yes 2 N If Yes, Give		гт 📗 '		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		k, White,	
21215-0036 signer. The Madreal Evanira	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🂢 No	Specify:		Specify	:	WHITE
15-C	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	tent's Usual Occup	ation during most of world)	king	6b. Kind of Bu	siness/In	dustry
d 212.	ошо	Elementary/Secondary (0-12)	College (1-4or 5-	+)		RIETOR	1)		AUTOMOB	II E	TIRES
~ ~ # # # PE E	Be C	17. Father's Name (First, Middle, Last,)				18. Mother's Nam	ne (First, Middle, M			
	2	HARRY			REIC	!	MINNIE		ICE		
01 00 00		19a. Informant's Name/Relationship (BEATRICE REICHMA		- 1				ral Route Number, LUTHERV			
ore, Mest and 2 Health item 27 in other tree		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Pla	ce of Dispo	sition (Name of natory or other place			Oc. Location -	_	
imor Pages nent of i		1 X Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specil		1	-	GE CEMETE		7/2004	PIKES	VILL	E, MD
Baltimore, permit. Pages 1 a Department of Her Importent: If them any injury or othe once.		21. Signature of Fuperal Sorvine Licer	1588					L LEVINS(ROAD - PI			
		23a. Part1. Enter the disease, or com shock, or beart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a CA	RDI	omy	O PATHY					Onset and Death YEARS
/Medical Examiner		ſ	Due to (or as a	conseque	ence of):						
Ø.	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	. conseque	nce of):						
8760, sate be executed bhysician and the burial-transit	Examiner	cause. Enter Underlying Lause (Lisease of Injury that initiated events resulting in death) Last	c								
38760, icate be ex physician a the burial.	a E	resoning in county East	Due to (or as a	. conseque	ince of):						
sate 87	edlcal		_ d								
Records, P.O. Box 6: The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physiclan/Me	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnancy			23d. Date		,
P.O. Box nat the death cer d by the attendin	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at t			Other (specify)			Mor	ith	Day Year
ds, P.O. I		Part II. Other significant conditions of	ontributing to death bu	t not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contr	ibute to th	ne cause of death?
rds. quires	ed by	mesenteric	ischemi	a				1 ☐ Yes	2 □ No	3 🔀 Prob	pably 4 DUnknown
ecord law requir as been s 2 should	plet							24a. Was an autopsy	24b. V	Vere auto	psy findings available mpletion of cause of
Vital Rec sicien: The law certificate has t	Completed							perform	ed? d	eath?	
Vita vicien: vertific	Be	25. Was case referred to medical examiner?	Hospital:			Oth		th (Check only one	-	-	
Of Phys	: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Injury (Month, Day		R/Outpatien 8b. Time of	28c. Injun Worl	4 Li (valsing i i	ome 5 Resider			1)
sion anding ath. or: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n	Year)	Injury		k? Yes 2 □ No				
Division of Vital Records, or Attending Physicien: The law requires that I death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At hom (Specify)	e, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	r or Rura	I Route Number,
ite si si si si si si si si si si si si si		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowl	adae death	occurred at the tim	o date and place	and due to the ser	(a) and		
se Hos	Medical	(Check only 2 Medical Exar	niner: On the basis of and manner stat	examinatio	n and/or inv	estigation, in my of	pinion, death occur	red at the time, dat	e and place, a	nd due to	the cause(s)
To th withir comp	M	29b. Signature and title of certifier	MA			29c. License		1	d. Date signed		
*		· wat	MD			D0060	0632	M	ovember	- 5	2004
10		30. Name and address of person who Ben Herman MD	completed cause of de			,	N MD	21204			
Stat	te	31. Date filed (Month, Day, Year)	32. Registra			, , , , , ,	77 77()	-1207			
Registra	ar	NOV Q 9 2004	A serve	K	Coas	60					

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day John Joseph Ricketts Vovember 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Levindale Hebrew Geriatric Center Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2□F 80 219-14-1504 Director 10/27/1924 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show emy injury or other traumatic event, the Medical Examinant must be indiffed at once. 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits Director MD Baltimore Baltimore 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 Meadow Road 21206 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑XYes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Joseph Ricketts Edith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Ricketts/Wife 504 Meadow Road Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith `4 ☐ Donation 5 ☐ Other (Specify) 11/9/04 Baltimore, M aryland 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Furnaral Service Licenses 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease of shock, or heart failure liver Immediate Cause (Final plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death **Physician** letastatic disease or condition resulting in death) Lung CANCER Lyear /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): burial-transit Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ orary ARTERY 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 2 🗌 No Sores 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) autopsy performed? (es 2 No Kenal failure Chronic 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 Inatural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: / filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mather as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reliederether Balto. 2434 31. Date filed (Month, Day, Year) 32. Registrar's Sign yure State Registrar NOV 0 9 2004

			1 - For State Ragistrar	State of	f Marylar	nd / Depa <i>Cei</i>	artment of Hoteline	ealth and Death	Mental Hygi	en2004	35422
	Dhuais		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medi		Edna C. S	tuart					Nov. 5,	Day Year 2004	8:26P ^M
	Examir		4a. Facility Name (If not institution, give		•		4b. City, Town, or	Location of Deat	h	4c. County of Dea	
			7851 East Baltimo					imore		<u>Baltimo</u>	
	Funeral Director		5. Social Security Number 6. Se 224–18–5963	x □M 2 X □F	7. Age (In yrs.	83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day, 1	$\stackrel{\text{(ear)}}{1921} \stackrel{\text{9. Bij}}{\stackrel{\text{(i)}}{V}}$	thplace (State or Foreign ountry) irginia
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Mary Feat	to	Maryland Balti	nore		Ba1	timore				1 Tyes 2 No
	h the	irec	10e. Street and Number				10f. Zip Code		109	g. Citizen of What C	ountry?
	th wil	alD	7851 East Baltimo	re Stre	et			21224	1	USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ※Widowed 4 □ Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? 2 XNo e	1	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 🎇 No	panic Origin? (S , Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	te, etc.
ŏ	2 hou	ted	15. Decedent's Edu	ıcation		16a. Deced	ent's Usual Occupa	tion	16	Sb. Kind of Business	/Industry
21215-0036	within 7 iene. r than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	le <i>completed)</i> College (1-	-4or 5+)		kind of work done di DO NOT use retired) Memaker	uring most of wo	rking	Own Hor	
	e filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle, Ma		
Maryland	uld be Jenta rked tic ev	ToB	Mack Tilson					Ali	ce Myers		
ar)	2 sho and t	Ė	19a. Informant's Name/Relationship (T)	γρe, Print)		19b. Mailin	g Address (Street ar		ıral Route Number, (City or Town, State,	Zip Code)
	is 1 and 2. If Health a item 27 is other trau		Barbara Elbourne	[/] Daugh		7851	East Balt	imore S	treet Balt	imore, Ma	aryland 21224
00	ges 1 If of H or ot		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F	Removal from S	State 20b. F	Place of Dispos cemetery, cren	sition (Name of natory or other place)	Date 20	c. Location - City or	Town, State
altimore,	t. Pa rtmen rtant: njury	0	4 □ Donation 25 □ Other (Specify)		Met		matory In		08/04 Ba	altimore,	Maryland
Ba	permi Depa Impo any ii	. 10	21. Signature of Funeral Service Ucens Thomas Gregor	·		22 C 2	Name and Address remation 99 Freder	sof Facility Society ick Road	Of Maryla 1 Baltimor	and Inc.	and 21228
П			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that ca	used the deat ich line.	h. Do not ente	er the mode of dying	, such as cardiad	or respiratory arres	l,	Approximate Interval Between
	Pnysician	i i	Immediate Cause (Final disease or condition	9	Tould	E LU	N Car	r.a.			Onset and Death
	/Medical Examiner		resulting in death)	Due to (d	or as a consec	juence of):	1				ı
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	mence off:					
	ned Insit	Examiner	Cause (Disease or injury	200 10 (1	, as a sonsoq	uonos on).					
,	execu n and ial-tra	Exai	that initiated events resulting in death) Last	Due to (c	or as a conseq	uence of):					
68760,	icate be executed physician and s the burial-transit	dical		d							
_	tifica ng ph as th	ω .									
Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	in the past 12 months?		th 2 ☐ Feta int at time of d	Ideath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
0.	at the	Phy	9 Unknown								
rds,	equires the	by	Part II. Other significant conditions co.	ntributing to dea	ath but not res	ulting in the un	derlying cause giver	in Part I.			the cause of death? obably 4 🗷 Unknown
Records,	e fav has je 2	Completed							24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
Vital		0	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes 2.2 th (Check only one)	No 1 □ Yes	2 No
	Physic this ce ral direc	ToB	examiner? 1 ☐ Yes 2 No	lospital: 1 🗌 In	patient 2	ER/Outpatient	Other		ome 5 Residence	e 6 □Other (Spec	cify)
0	ding Pt h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe how		,,
Sio	Attendi death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be					es 2 □No			
Division of	tal or At s after d al Direct ed in by	Certification;	4 Homicide determined	28e. Place of building	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the base ner: On the base and manner	sis of examina	wledge, death tion and/or inv	occurred at the time estigation, in my opin	, date and place, nion, death occur	and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		2		29c. License r	number	29d.	Date signed (Month	t, Day, Year)
			In will !	Last 14	splera	1	01471	4	1	1/7/104	
,	μ		30. Name and address of person who co	mpleted cause	of death (Item		Print) EAGEN	Ale B	9271MUN 1	nd 2/224	1
	Sta Registr	_	31. Date filed (Month Day, Year) 200	32. R9	gistrar's Signa		Sports	/	, , ,		
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.TN	SIMPSO	M		Plea	ise Type or												
1717	Dilloc		For State Registrar		State	of Ma	aryland	I / Depa Ce	artmen <i>rtificat</i>	it of H e of L	lealth D <i>eath</i>	and N	Mental Hy	/gie Reg) 4	35423
п			1. Decedent's Nam	e (First, Midd	le, Last)								2. Date of D	eath	D		3. Time of Death
	Physicia /Medic		Mar1	in Van	ce Simpso	n							Month NOV.		Day 4, 20	Yeer 04	0826 A
12	Examin		4a. Facility Name (i	If not institution	n, give street and nu	ımber)			4b. City,	Town, or	Location	of Death			4c. Count		
36			49 LEV	VIS DRI	VE				A	BERD	EEN				HARF	ORD	
	Funeral		5. Social Security N	lumber	6. Sex	7. Age		st birthday)	If Under		If Under		8. Date of Bi	rth	1	9. Birth	place (State or Foreig
	Director		Unknown		1 ∑ M 2□F		3	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Aug 9,	^{ay} 15	70		yland
	D .		Usuel Residence of														
	how	.	10a. State	10b. County			10c. City,	Town or Lo	cation								10d. Inside City Limit
:	n the Marylan r 28a-f ehow notified at	cto	Maryland	Har	ford			Abe	rdeen								1 □ Yes 2 □ N
	or 28	Directo	10e. Street and Nu	mber					10f. Zip	Code	*			10g.	. Citizen of	What Col	intry?
	E m = 5		49 Lewi	s Driv	e					21	001				US	SA	
	nours affer dea urel', or Itams	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		If You G	orces? 2 XN ive			Was Deced If Yes, spec 1 ☐ Yes		ispanic Or n, Mexica Specify:		ecify Yes or N Rican, etc.)	0-	Bla	ce - Amer ck, White by: Whi	
	netui	eted	(Spec	15. Deceder	it's Education st grade completed))		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa	ation furing mos	st of work	ring	168	b. Kind of B	usiness/l	ndustry
121	than the	ompleted	Elementary/Seco	ndary (0-12)	College (1-4or 5	+)		ninis)		J	F	Bell M	lachi.	ne
ם	al Hyg d other	BeC	17. Father's Name	(First, Middle,	Last)						18. Moth	er's Nam	ө (First, Middle	1			
<u>a</u>		٥	Roger L	aine S	impson						Shi	rley	7 Arnol	d			
a	and and		19a. Informant's Na	ame/Relations	thip (Type, Print)			19b. Mailir	ng Address	(Street a	and Numb	er or Rur	al Route Numb	er, C	ity or Town	State, Zi	p Code)
Σ :	alth 27 I		Shirley	Hoopen	garner			462	7 Aus	tin 1	Parkw	ay S	Sugarla	nd,	Texa	s 77	479
ore.	of He of He of He or other		20a. Method of Disp		3 □Removal from	State	20b. Pla	ce of Dispo	sition (Nan	ne of ther place	9)	=== 1_1	Date	200	. Location	- City or T	own, State
Ē	ent:		` 4 ☐ Donation			Olalo	Met	ro Cre	emato:	ry I	nc.	11/0	06/04	E	Baltim	ore,	Maryland
Dall	Departi Departi Import any Inj once.		21. Signature of Fu	ineral Service	Licensee			C1	. Name an Cemat	d Addres	s of Facili	ety (of Mary	lan	ıd Inc		2 21 220

Physician /Medical Examiner

Examiner by Physician/Medical Completed Be Certification:

signed by

peen

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien:

within 24 hours after death. To the Funerel Director; After

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

IF FEMALE:

21. Signature of Funeral Servicer Licensee
Thomas Gregor

Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4□Pregnant at time of death

Intraoral

Due to (or as a consequence of):

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

shotour wound

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9□ Unknown

1 ☐ Yes 2 ☐ No autopsy performed?

299 Frederick Road Baltimore, Maryland 21228

3 ☐ Probably 4 ☐ Unknown

Day

1□X/es 2□No 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE

25. Was case referred to medical examiner?

1 X Yes 2 No 27. Manner of Death 1 Natural

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Pending investigation

28a. Date of Injury 28b. Time of Gund Work?

N-4-04

8:34 AM

1 | Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at home

1 ☐ Yes 2 🗷 No

28d. Describe how injury occurred 5015

28f. Location (Street and Number or Rural Route Number,

(Check only 29b. Signature and title of certifier

2 Accident

3 Suicide 4 Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be determined

29c. License number O.C.M.E

NOV. 5, 2004

Medical

State Registrar

36 Name and address of person who completed PATRICIA ATANICA
31. Date filed (Month, Day, Year)
NOV 0 9 2004

Maryland 21201 32 Registrar's Signature

equse of death (Item 23a) (Type, Print)

		1 - Star	te jistrar	;	State of	Maryla	nd / De <i>C</i>	partmo	ent of F ate of	lealth <i>Death</i>	and M	lental H	ygien Reg. N		14	3542	5
	ician dical		dent's Name <i>(First, Midd</i> Valter Alle	,	eicher							2. Date of E Month NO VE	Death		Year 4	3. Time of Death	1
4	niner	ma	ty Neme (If not institution Security Number	6. Sex	al A	105pi	tal	Bar Ir Un	ty, Town, o	LORE If Unde	CT7 or 24 Hrs.	Ly Sate of B	3irth		N/A	lace (State or Foreig	חו
Direct			-28-8448 esidence of Decedent	1.80	M 2□F	/3	Yrs	Monti	ns Days	Hours	Min.	Mar.	16, 1	931		yland	_
death with the Maryland ms 23s or 28s-f show	Director		land N	/A			Baltin								10	0d. Inside City Limits 1.□Yes 2□No	
with th			et and Number .6 Newport A	Avenu	e			10f.	Zip Code 21	211			10g. C	itizen of Wi US <i>A</i>		itry?	
after or Ite	by Funeral	11. Marit	al Status Never Married 2 ☐ Ma Widowed 4 ☑ Divorce	rried 12	. Was Deced Armed Forc 1/2/Yes 2 If Yes, Give Year or Date	es? ∐ No						ecify Yes or N Rican, etc.)	10-	14. Race	- America , White, e	etc.	_
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after tt of Health and Mental Hygiene. It Item 27 is marked other than "natural", or ite	Completed	Eleme	15. Decede (Specify only high ntary/Secondary (0-12) 12		tion		16a. De (G life	ive kind of b. DO NO	sual Occup work done use retired y Gua	during mo d)	st of worki	ng		Kind of Bus		•	_
Maryland 2 d 2 should be filed th and Mental Hygi tr 11s merked other traumatic avent, II	To Be C	17. Fathe	er's Name <i>(First, Middle</i> ght Eugene	Spei	cher						ner's Name Mary	(First, Middl Rush					_
e, Maryla 1 and 2 should Health and Men sm 27 is merke ther traumatic		Ar1	ormant's Name/Relation ene Abel1 hod of Disposition		o, <i>Print)</i> Compan		19b. Ma	4416	Newp		Avenu	e Bal	timo		lary1	and 21211	
Baltimore, N permit. Pages 1 and 1 Department of Health Important: It item 27 any injury or other fr	ا نه	1 🖾	Burial 2 Cremation Donation 5 Other (Specify)	noval from St	ato	cemetery, c l. Vet	rematory o erans	Ceme	tery	11/	10/200	4 Ga	rriso	n Fo	rest. MD	_
Department of the state of the	800c	Y	Ment	Chi	pout	u		Burge 3631	e-Hen Falls	ss-Se Road	eitz 1, Ba	Funera 1timor	1 Ho e, M	me, I aryla	nc. nd	21211	
Physicia /Medic Examin	al	Immedia disease	rt1. Enter the disease, cock, or heart failure. Lis ate Cause (Final or condition j in death)	or complicationly one	COR (n line.	ma	of f	the ailu	Pr	os tardiac o	ate	arrest,			Approximate Interval Between Onset and Death	
8760, State be executed any sicient and the burial-transit	dical Examiner	Sequent if any, le cause. Cause (that initia resulting	ially list conditions, ading to immediate Enter Underlying Disease or injury ated events in death) Last	c		as a conse		<u></u>	OLI TO								
Box 6 eath certification attending processes as	by Physiclan/Med	in t	LE: s decedent pregnant he past 12 months? Yes 2 No	230	: If yes, outco 1 □Live birth 4 □ Pregnan 9 □ Unknow	n 2 ☐ Fet t at time of	al death	3 Ectopic 5 Other	pregnancy (specify)					23d. Date Mont		ry Day Year	_
rds, P.O. quires that the din signed by the old be detached	ed by Pt	Part II. 0	ther significent condit	ions contri	buting to deat	h but not re	sulting in the	underlyin	g cause give	en in Part	l.		tobacco		oute to the	e cause of death?	_
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of Vit	To Be		case referred to medica niner? Yes 2 No		spital: 🗶 Inp	atient 2] ER/Outpat	ient 3	DOA Othe			Check onl ne 5 ☐ Res		6 □Other	(Specify))	
Division of lor Attending Physalter death. Director: After this lin by the funeral di	atlon:	ıXı	190100.11	tigation	28a. ate of l (Month,	njury <i>Day</i> Ye <i>ar)</i>	28b. Time Injur		28c. Injun Work		2	28d. Describe					
Division of Vital Re To the Hospital or Attending Physician: The Within 24 hours after death. To the Puneral Director: After this certificate his compisitely filled in by the funeral director, page	Certification:		Suicide 6 ☐ Could Homicide deterr	not be mined	28e. Place of building	Injury - At h , etc. <i>(Speci</i>	nome, farm, ify)	street, fact	ory, office		2	28f. Location City or To	(Street ar	nd Number e)	or Rural	Route Number,	_
the Hospi in 24 hou the Funer	Medical	on	eck only Z Medical	I Examine	ian: To the be r: On the basi and manner	s of examin	owledge, de ation and/or	ath occurre	ed at the time on, in my op	ne, date a pinion, dea	nd place, a ath occurre	and due to the ed at the time	cause(s , date an) and manr d place, an	ner as sta d due to t	ated. the cause(s)	
To To Com	Σ	29b. Sig	nature and title of certific	er L	a FI	loma	SN		9c. License	154	0		29d. Da	te signed (Month, D	Dey, Year)	
	1	Jas	on Thor	who com	M.D	of death (Ite	m esa) (Typ	Print)	and	Gré	nero	al 1	40	pit	al	Treatment	
	State strar	31. Date	filed (Month Pex Year	9 200	32. Reg	istrar's Sign	ature	<i>e</i>									_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 35426 For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) NOVEMBER 4, **Physician** SITZAMER 2004 Рм 4:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 3317 NORTHMONT ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth MAY 3, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔽 F 82 Yrs RUSSIA 217-62-0493 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 No Directo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 USA 3317 NORTHMONT ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DORIOMEDOVNA (UNKNOWN) (UNKNOWN) EMELIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 N. ARMISTEAD STREET - ALEXANDRIA, VA 22312 SABINA HAAR / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 11/07/2004 * 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** coronary artery disease or condition resulting in death) /Medical Due to (or as a cons uence of): **Examiner** hupertension. Sequentially list conditions, if any, reading to infirmediate cause. Enter Underlying Cause (Disease or injury Que ty (or as a consequence of) Examiner hypercholesterolenna The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 hknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2□ No 1 Yes 2 X No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔏 Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 27. Manner of Jeath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) NOV 0 9 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + 400 Owngs Mills MD 21177 32. Registrar's Signature

053968

november 5, 2004

STOTIER, Phillip

	4	Please 1 - State Registrar	Type or Prin		d / Depa		lealth and M			gible.	35427
Physicia /Medic		1. Decedent's Name (First, Middle, La Phillip Darrell	stotler					2. Date of Do Month	Day	Yeer 2004	3. Time of Death
Examine		4a. Facility Name (If not institution, gives Stella Maris Hosp	pice At Me			Baltimo				unty of Death	h
Funeral Director		5. Social Security Number 215–66–3071 Usual Residence of Decedent	fex 7. Ag	46	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. March	irth ay, Year) 13,1958		nplace (State or Foreign untry) Yland
Maryland	ctor	10a. State 10b. County Maryland Baltimon	re		r, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with the Maryland ms 23s or 28s-f show Frest be nutilized	ral Director	10e. Street and Number 605 Delaware Aver	nue			10f. Zip Code 212	21			of What Co	untry?
	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ※ Wivorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Amei Black, White ecify: Wh	rican Indian, e, etc. ite
CLISIONOS after filed within 72 hours after Hygiene. http://www.insturef., or lie and, the Malical Exertified and, the Malical Exertified in the Mal	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	i+)	(Give	ient's Usual Occup kind of work done DO NOT use retired	during most of worl	king	16b. Kind o	of Business/l	
yland ZI.	Be	17. Father's Name (First, Middle, Last)		Facto	ory Worke	18. Mother's Nam		Facto , Maiden Sur		
Mar d 2 sh h and 7 ls m traum	ဥ	Willard Bernard S 19a. Informant's Name/Relationship (Donna Gail LeDane	Type, Print)		19b. Mailir	ng Address (Street	Dolly Ma and Number or Run prings Ro	ral Route Numb	per, City or To	wn, State, Z	^(ip Code) 25428
partilliore, was permit. Pages 1 and Department of Health Important: If item 27 any injury or other trees.		20a. Method of Disposition 1 Surial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	CE	lace of Dispo emetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Locati	on - City or 1	Town, State
DEALLIMOT permit. Pages Department of tmportant: If it any injury or o		21. Scooling 15 process		bac	22	. Name and Addre	esus 11/0 ss of Facility uzdziński Eastern A	Funera	al Home	, P.A	Maryland land 21221
Physician /Medical		23a. Part1. Enter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each li a	tcy.	. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
price pe	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as								
auth cert attendin for use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,		23d.	Date of delive	very Day Year
w requires that the de	leted by Pt	Part II. Other significant conditions (contributing to death b	ut not resu	liting in the u	nderlying cause giv	en in Part I.	23e. Did 1	-1	100	the cause of death?
	Complet							24a. Was auto perfo		tb. Were autorior to condeath?	opsy findings available ompletion of cause of
the signal	ertification: To Be (25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatio			ER/Outpatien 28b. Time of Injury	28c. Injun Wor	26. Place of Deat er: 4 Nursing Ho y at k? Yes 2 No		idence 6 🗗	Other (Speci	Whospice
tel or Atters after de el Directo	Certific	3 Suicide 6 Could not be determined		ury - At ho	m e, farm, str	eet, factory, office		28f. Location (City or To	Street and Nu wn, State)	ımber or Rur	ral Route Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Example one)	nysicien: To the best niner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	estigation, in my o	pinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as : ce, and due i	stated. to the cause(s)
with To 1	Σ	29b. Signature and title of certifier	~/\~			29c. Licens	9854		29d. Date sig	gned (Month)	Day, Year) 2009
2		30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of d	01 5	23a) (Type,	UI PI	Ballina	ire m	d. 2	1202	,
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiener 35428 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SCHEL NDLINGER MORRIS 2230 M NOVEMBER /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner JOHNS HOPKINS BAYVIEW CARE CENTER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec.31,1936 **Funeral** 1 G M 2 □ F 219-32-4653 67 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Show N/A Baltimore City 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò other traumatic event, the Medical Examiner must be 21224 137 N. Linwood Avenue U.S.A. 238 Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1□ Yes 2√ No þ Specify: Specify: 3 Widowed 4 Divorced White Year or Dates: natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Coltege (1-4or 5+) Machinist 12 Westinghouse other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: If item 27 is marked other any injury or other transmitted other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dr. Morris I. Scheindlinger, Sr. Leona McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosario Scheindlinger (Wife) 137 N. Linwood Avenue Baltimore, Maryland 21224 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Oak Lawn Cemetery 11/8/04 Baltimore, Maryland 21. Signal Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition LUNG CANCER **Physician** 6 months resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Atrial tibrillation coronary artendisease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 20 Unknown should been diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1 Yes 2 XNo director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 2 and manner stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 10 5505 Hopkins Michelle Bellantoni, MD Barriew Circle Baltimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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NOVEMBER

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State of Maryland / Department of Health and Mental Hygiene 004 35430 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 1:03 P M Turner Sr. November 5,2004 Joseph /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Stella Maris - Towson Towson ff Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 18, 1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**X** M 2□ F 93 263-18-4287 PA. **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 77 Is marked other than "natural", or itams 23a or 28a-f ahow traumatic avant, the Neulcal Exercited county be redified at 1 ☐ Yes 2 No Dundalk Director MD Baltimore 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 21224 USA 7911 Bank Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Structural Iron Worker 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd Mental I Mary Vida Joseph P. Turner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health aitam 27 l 7982 Honeygo Blvd #42, Batlimore, MD. 21236 son Joseph C. Turner Jr. other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Himportant: If its any injury or of once. November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 11, 2004 Baltimore, MD 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service License bethou 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each lime. Approximate Interval Between Onset and Death 1/14/2 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown o. Part If. Dther aggrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be det þ Records, 1 Yes 2 No 3 Probably 4 Niknown Completed 65 NST2/1630 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 After this of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Hospital or Attanding 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To tha Funeral Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature as 504 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093 EDDIE NAKHUDA, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Danie WOLV Q 9 2004 oaks Registrar

JOVEMBER

State of Maryland / Department of Health and Mental Hygier 0 0 4

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1	Physician /Medical		ELMA	TUCKER				2. Date of De Month	Dey	Year 2004	3. Time of Death 11:20 AM
	Examiner	4a Facility Name (If not institution FUTURE CARE C					4b. City, Town, of ARNOLD	r Location of Deat	h 4c. County ANNE		DEL
	Funeral Director	5. Social Security Number 217–18–2705		8 (In yrs. last birthd 8 2 Yrs	Months	or 1 Year Days			th 2 Year)	9. Birthp Court	place (State or Foreign http) MD
	pug *	Usual Residence of Decedent 10a. State 10b. County	<i>y</i>	10c. City, Town o	Location						Od Innida Cit. Limita
	th with the Marylar 23s or 28s-f show ust be notified at al Director		Arundel	Linthi							0d. Inside City Limits 1 ☐ Yes 2 🖔 No
	3a or 24 at being	10e. Street and Number 23 Colonial D	rive		10f. Z	ip Code 2109	90		10g. Citizen of US		ntry?
020	aftar daa r ftems niner m Funer	11. Marital Status 1 Never Married 2 Mar 3 🛱 Widowed 4 Divorced	W 1/ O:	ever in U,S.			Hispanic Origin? (pan, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Rac Bla Specifi	ce - Americ ck, White,	
Ş	the start		nt's Education	16a De	cedent's Us	ial Occur	nation		16b. Kind of B	usin oss /los	huston
21215-0020	within ana.	(Specify only higher Elementary/Secondary (0-12)	ost grade completed) College (1-4or 5-	(G iii	ive kind of w e. DO NOT aitres	ork done use retire	during most of we	orking		auran	
Maryjand 2	ould be filed Mantal Hygi srked other atic event, I	17. Father's Name (First, Middle, William	Last) Dreier					ame (First, Middle	, Maiden Surnan Stahl	ne)	
	ind 2 sho alth and 27 is m	19a. Informant's Name/Relations Mr. Kevin Ritz						Ru <i>ral Rou</i> te <i>Numb</i> Chicum MI		State, Zip	Code)
Baitimore,	Pagas 1 a nant of Hei nt: If Nem iry or othe	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		20b. Place of Dicemetery, of Meadowr	rematory or	other pla		Date 11/6/04	20c. Location -		
i	bemit. Pa Depertman mportant: Iny Injury MCB.	21. Signa are of Funeral Se						Singletor	Funore	1 11	D A
Ď	Dec Ing	Donnal	allas mo	13/24	1 Seco	ond A	Ave SW,	Glen Bur	nie, MD	21061	le r.A.
		23a. Fail 1. Enter the disease, of shock, or heart failure. List	r complications that caused tonly one cause on each lin	the death. Do not	enter the mo	de of dyi	ng, such as cardia	ac or respiratory a	rrest,	1	Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition	Pne	uma	nia					(Onset and Death
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ox 68760,	cartificata be axecunding physician and use as the burial-trany	that initiated events resulting in death) Last	C	oue to (or as a cons	sequence of)	;					
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o O	tha attar hed for u	Part II. Other significant condition	ons contributing to death but	not resulting in the	underlying	cause giv	en in Part I.	23b. Did	tobacco uae cor	ntribute to	the cause of death?
s, P.O.	es that the daal igned by tha att ba dateched fo by Physicia	Advancec	demer	tia				1 🗆	Yes 2□ No	3 Prob	ably 4 1 Whiknown
Division of Vital Records,	raquir bean s should						-	24a. Was perfo	an autopsy rmed?	ava	re eutopsy findings illable prior to appletion of cause death?
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ita	slan: artifica totor, Be (25. Was cese referred to medica examiner?						ath (Check only o	ne)		
=	Physician: r this cartific irel diractor, I: To Be (1 ☐ Yes 200 No	Hospital: 1 Inpatien				4 LUNUISING I	Home 5 🗆 Resid	dence 6 □Oth	er (Specify)
ono	Attending Pt or daath. ector: Aftar th by tha funare iffication:	27. Menn Deeth 1 Datural 5 Pendir 2 Accident investi		Year) 28b. Time	o of y M	28c. Injur Wor 1 □	yat rk? Yes 2 □ No	28d. Describe I	now injury occurr	ed	
Divis	7 - F	3 Suicide 6 Could 4 Homicide determ		y - At home, farm, (Specify)	street, factor	y, office		28f. Location (S City or Tox	Street and Numb vn, State)	er o <i>r Rural</i>	Route Number,
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	Ä	30. Name and address of person	edinger 8	601 Vet	e, Print)	Hu	vy Mil	lersvil	le Ni	10 5	21/08
	State Registrar	31. Date filed (Month, Day, Year)	32. Registrar		Spa	de			r		

State of Maryland / Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year ROBERT WRIGHT NOVEMBER 07 2004 11:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL RANDALLS TOWN NORTHWEST CENTER BALTIHORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex 9. Birthplace (State or Foreign Country)
BALTIMORE **Funeral** 1 M 2 F 240-48-0096 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be institled at 1 Yes 2 □ No Directo MARYLAND 10e. Street and Number Og. Citizen of What Country? 204 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 2 Yes 2 No
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates: ACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event. It is Med Elementary/Secondary (0-12) College (1-4or 5+) 8 HITGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUDBROOK LANE LDA SHIRLEY WRIGHT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State COWNSVILLE CEMETERY 11-15-04 CROWNSVILLE * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pagility 21. Signature of Funeral Service Licensee BROWN -ULTONAVE. ALTO. MD. 2121 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PSEUDO MEMBRANOUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed FITTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ALZEIMER 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes ②XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature an the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42723 2004 NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST HOSPITAL AVVERAHALLI M HARISH 5401 OLDCOURT 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NOV 0 9 2004

State of Maryland / Department of Health and Mental Hygien 0 1 1 - For Stete Registrar 35433 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year TSTON 0240 PM /Medical ON 2004 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE AGNE HEALTH CARE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 32-988 250-Days Hours 12M 2□F South CAROLINA Director Yrs. JUNE 10 Usual Residence of Decedent death with the Maryland 10a. State 10b County 28e-f show 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examinar must be notified at Director 1⊠Yes 2□No MARYLAND 10e. Street and Number 10g. Citizen of What Country? or Items 23a or USA Completed by Funeral d 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or lien eny injury or other traumatic event, the Medical Experiment 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE PNSTRUCTION 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) (MN -UNKNCいい) HARRY ပ္ WHETSTONE 19a. Informant's Na e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TANGERINE STEWART UPMANOR 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 △Surial 2 □ Cremation 3 □ Removal from State CEMETERY 11-1. * 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE RESPIRATORY
Due to lor as a consequence 1): DAYS /Medical **Examiner** 2 DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Live birth 2 Fetal death ρ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 🗆 No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a Wasan certificate has autopsy performed? Yes 2 No 1 ☐ Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ٩ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of after death. 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as size.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL -SA10 90 0 CA
32. Registrar's Signature CATON AVE 31. Date filed (Month, Day, Year) State Registrar NOV 0 9 2004

WHITSTONE

State of Maryland / Department of Health and Mental Hygie Pe 1 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 000 : 10 PM OVP 22004 Vovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Elizabeth Itimore enter WYSING 150 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. Jear) | April 13,1898 5. Social Security Number 6. Sex 7. Age (Ir yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 X F 212-09-9537 106 Director Yrs Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Count item 27 is marked other than "netural", or Items 23a or 28e-f show other traumatic event, the Medical Example rives by political at 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 East Churchhill Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 🕱 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S. Printing & Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Lithograph Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Smith E11a Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 It Elaine D. Eble (Niece) 7268 Forest Avenue, Hanover, Maryland 21056 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any njury or once 11-11-04 `4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland New Cathedral Cem. Cully-Polyniak Funeral Home P.A. 21230 O East Fort Avenue, Baltimore, Maryland 21. Signature of Funeral Service Licensee rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician secondary to pleura typoxemia disease or condition resulting in death) WKS /Medical Due to for as a consequence of): Examiner ardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit men Due to (or as a consequence of): the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown for Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe oidism 3 ☐ Probably 4 ☐ Unknown Be Completed 1 ☐ Yes 2 ☐ No page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 2**A** No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check on one) 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After tha Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death Director: / the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 8, 2004 30. Name and address of person who complete ca se of death (Item 23a) (Type, Print) Baltimore Maryland 3320 Avenue enson 32. R strar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 0 9 2004

Division of Vital Records, P.O. Box 68760,

04-	07118			Please	Type or Prin	nt in B	Black	Indelib	le Ink	. Ensure A	II Copies	Are Leg	jible.	
RKD					a&Unpend	tem	23a	epartme Certifica	ent of h	lealth and 1 er me G83 Death ta			04	35435
	Physici /Medi			ne <i>(First, Middl</i> e, La: ATTHEW	STANLEY	WH	ITE				2. Date of De Month NOVEME	BER 3, 2	2004	3. Time of Death 8:49P. M
	Examir				street and number) 803 Wilda	Driv	e		•	or Location of Death NSTER		4c. Coun	ty of Death	
5	Funeral Director		5. Social Security N 216-90-76	556 1	CH 005	e (In yrs. I 41	last birth	Month	der 1 Year S Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec . 24	rth ay, Year) 4, 1962	9. Birth Cou M	place (State or Foreigr Intry) D
	yland how		Usual Residence of 10a. State	10b. County		10c. City	y, Town	or Location						10d. Inside City Limits
	he Mar	Director	MD	Carrol	1				-	nster		10- 6::	L NATH OLD COL	1 ☐ Yes 2 No
	3a or 3		10e. Street and Nu 803 Wild					101. 2	Zip Code 21	157		10g. Citizen o	SA	intry ?
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Man 3 □ Widowed	ried 2🕅 Married 4 🗆 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 【XI If Yes, Give Year or Dates:		S.			dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14. Ra		
21215-0036	"natur	Completed	(Spe	15. Decedent's Ecify only highest gra			16a. D	ecedent's Us	sual Occup work done	pation during most of work d)	ing	16b. Kind of	Business/Ir	ndustry
212	d withir giene. rr than	omp	Elementary/Sec	ondary (0-12)	College (1-4or 5	5+)				anager		Restau	ırant	
pu	be filed ital Hyg id othe event,	Be		(First, Middle, Last)						18. Mother's Nam		, Maiden Suma		
Maryland	should nd Mer marke nmarke	2		ley A. Wh			19b. N	Mailing Addre	ss (Street	Brenda and Number or Run	A. Her		n, State, Zi	p Code)
2	and 2 salth ar		Mrs. Sus	an M. Whi	te (Spouse		803	Wilda	a Dri	ve Westmi				
Jore	ages 1 nt of H :: if iter			Cremation 3 □	Removal from State	20b. P	lace of E emetery, CO11	Disposition (No crematory of	lame of r other plac remat	Srv. ion 11/7	Date / O/L	Sykesy		
Baltimore,	permit. Pages 1 and 2 Department of Health a importent: if item 27 is any injury or other tree			5 □ Other (Specify uneral Service Licer Man A		7		-		ss of Facility ERAL HOME , MD 2178		_		
	Physician		23a. Part1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List only (Final on	plications that super one cause on each line a. Olanzapi	ne.	n. Do no	t enter the m	ode of dyir				400	Approximate Interval Between Onset and Death
68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and completely filled in by the funeral director.	dical Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease on that initiated event resulting in death)	onditions, mmediate erlying r injury s	Due to (or as b. — Due to (or as c. — Due to (or as d. —	a consequ	uence of)):						
P.O. Box 6	res that the death certifi igned by the attending be detached for use as	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death	3□Ectopic 5□ Other (1			ate of deliv	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other signi	ficant conditions of	ontributing to death b	ut not resu	ulting in t	he underlying	g cau <i>s</i> e giv	ren in Part I.		tobacco u <i>s</i> e cor Yes 2 □ No	ntribute to t	the cause of death?
Division of Vital Records,	victan: The law recentificate has be rector, page 2 sh	Completed									1 Yes	psy ormed? 2 \(\sum \) No	prior to co death?	opsy findings available empletion of cause of
r Vit	yeiciau is certii directo	o Be	25. Was case refe examiner? 1 X Yes 2		Hospital: 1 Inpatie	ent 2 🗆 I	ER/Outp	atient 3 [DOA Oth	26. Place of Deather: 4 Nursing Ho			her (Speci	fy) SCENE
ion oi	anding Ph lath. or: After th	Certification: T	27. Manner of Dea 1 Natural 2 Accident	5 Pending investigation	C 1	y Year)	28b. Tin 8:40 foun	ury M	28c. Injur Wor 1 🗌	Vos 25 No	_	how injury occu		ug
) ivis	or Atte	ertifle	3 Suicide 4 Homicide	6 Could not b determined	28e. Place of Inj building, et residence	ury - At ho c. <i>(Specify</i>	me, tarm	n, street, facto	ory, office		City or To	wn, State) 80	3 Wil	al Route Number, da Drive
_	To the Hospitel or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Co	29a. Certifier (Check only one)		ysician: To the best niner: On the basis of and manner sta	of my knov f examinat				ne, date and place,	and due to the		anner as s	stated.
	To the To the Comp	Me	29b. Signature and	Little of certifier	2 //			2	29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
			176	eidni M	King	lands ():	0	-	0.C	.M.E.	N	NOVEMBET	4,20	004
				ress of person who	completed cause of d	eath (Item	123a) (T <u>j</u>		Penn	Street, B	altimor	ce, Mary	rland	21201
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WILLIA	M EDWAR	D V		State of Maryland 23a,27,28a-f pe			ntal Hygier	2004	35436
•	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, L	ast) Edward U ive street and number)	Jeinen. 4b. City, Town, or JARRETTS	Location of Death	Date of Death		3. Time of Death 0614 A M
457	Funeral Director		5. Social Security Number 6. 220-21-3446 Usual Residence of Decedent	Sex, 7. Age (In yrs. Ia.	st birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign ntry) RYLAND
	death with the Maryland ms 23a or 28a-f show rmust be notified at	rector	10a. State 10b. County 10b. Street and Number	10c. City,	Town or Location ARRE TO S 101. Zip Code	VILLE			10d. Inside City Limits 1 ☐ Yes 2 No
5-0036	within 72 hours after death with ene. than "natural", or Itams 23a or to Modical Eventret must be	ted by Funeral Director	15. Decedent's E	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cuban	Specify:	y Yes or No- can, etc.)	14. Race - Amen Black, White, Specify: WKind of Business/In	can Indian, etc.
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r traumatic avant, It at Med	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Las	College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	uring most of working 4 ed 18. Mother's Name (F		NA	
Baltimore, Maryla	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, if a Madical Eventrer must be notified a once.	Tol	19a. Informant's Name/Relationship 20a. Method of Disposition 1 ∰ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	1 CR - Tather Removal from State 20b. Place cerr Place 20b. P	19b. Mailing Address (Street are of Disposition (Name of petery, crematory or other place) 22. Name and Address	4 Anne Date PUS 11-8-0	Ct., Jos. 04. Fa EWAURT	VOGE Y OF TOWN, State 1, Zip Location - City or To WE. FOR AIR, MA	114E2108
•	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		caine Intoxica		espiratory arrest,	7)112, 7113	Approximate Interval Between Onset and Death
1760,	te be executed ysician and e burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					
P.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 ☐ Ectopic pregnancy h 5 ☐ Other (specify)			23d. Date of delive Month	ry Day Year
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of Vital Records,	yalclan: The fa lis certificate has director, page 2	Be Completed	25. Was case referred to medical axaminer?		2	6. Place of Death (C	24a. Was an autopsy performed? Yes 2 Notes No.	prior to con death?	isy findings available apletion of cause of
Division of	tending Pheath. tor: After the	Certification; To	27. Manner of Death 1	28a. Date of Injury Forther, Day Year) Forther 11-4-04	, farm, street, factory, office	s 2 X No Unl	Describe how inju	ry occurred	AT SCENE Soute Number, Y Anne Lan
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	ledical	one)	nysician: To the best of my knowler niner: On the basis of examination and manner stated.	and/or investigation, in my opin	date and place, and ion, death occurred a	due to the second		
	To wit To		29b. Signatur and title of certifier 30. Name and address of person who	Hallan	Ma	umber • M • E	29d. Da NO	ite signed <i>(Month, D</i> V• 5, 20	
	Sta		31. Date filed (Month, Day, Year)	(An) mid 11	1 Penn Street,	Baltimore	, Maryla	nd 21201	
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		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment rtificate	of Health a <i>of Death</i>	and Mental Hy	/giene	004	354	37
Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of D	eath	Year	3. Time of	Death
/Medic	cal	Wayne John Wiened			1 =		Novemb			2:50	Рм
Examir	ıer	4a. Facility Name (If not institution, give 9 Fir Drive	street and number)			own, or Location of le Rive			unty of Death Ltimore		
Funeral		Social Security Number 6. S		(In yrs. last birthday	If Under 1	Year If Under 2			9. Birth	place (State o	or Foreign
Director		219 20 1055	^{KM 2□F} 65	Yrs.	Months	Days Hours	Min. 8. Date of Bi (Month, D. May 6,	1939	Cou	land	
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside C	ity Limits
Many	tor	Maryland Baltimore	9	Middle 1						1 Tyes	
th the or 28s	Director	10e. Street and Number			10f. Zip Co			10g. Citizen	of What Cou	intry?	
ath wi	raic	9 Fir Drive			212			USA			
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. Item 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, it a Musical Examinal must be notified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M If Yes, Give Year or Dates:	o 13.	Was Decedent If Yes, specify 1 ☐ Yes 2		gin? (Specify Yes or No , Puerto Rican, etc.)	1	Race - Amen Black, White ecity: Whi	etc.	
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21215-0036 od within 72 hours aff gjene. er than "natural", or it a Mudical Exami	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5-	(Give	kind of work of DO NOT use	done durina most	of working	TOD. KING	JI DUSII1633/II	idustry	
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and the fill and off	Be	17. Father's Name (First, Middle, Last) Edward Wienecke					r's Name (First, Middle		-		
Maryland d 2 should be file th and Mental Hy T is marked othe traumatic event.	၉	19a. Informant's Name/Relationship (Ty)	ne Print)	19h Maili	an Address /S		nor Barten				
and 2 sauth ar n 27 is		Dorothy Wienecke (,				ore, Maryla			Code)	
of Hear		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Name	of	Date		on - City or To	own, State	
Pages Pages ment of I ant: If its ury or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bayview (/9/2004	Baltim	ore, M	Marylan	ıd
Baltimore, permit. Pages 1 ar Department of Hea Important: If item:	-	1. Signature of Funeral Service License	- T	22 F	Name and A	ddress of Facility	eral Home				
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nding ath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	- 1	Work? 1 ☐ Yes 2 ☐ No		ow injury coo	Juliag		
DIVISION (all or Attending F s after death. IN Director: After sd in by the funer.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	/ - At home, farm, stre (Specify)	et, factory, off	ice	28f. Location (S City or Tow	itreet and Nu n, State)	mber or Rura	Route Numb	ег,
he Hosp in 24 hou he Funer pletely fit	edicai	29a. Certifier (Check only one) 1 Certifying Physical Certifying	ician: To the best of er: On the basis of e and manner state	xamination and/or inv	occurred at the	e time, date and in the second	place, and due to the o occurred at the time, o	ause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)	
To the troop of the troop	-	29b. Signature and title of certifier			29c. Lic	ense number	7	29d. Date sign	ned (Month, L	Dey, Year)	
			W)			11849		11/8	104		
6		30. Name and address of person who con	SIIH	th (Item 23a) (Type, I	Print) IPER	CIRC	att , sui	16-21	1, BA	au, N	15)
Stat Registra	e	31. Date filed (NOV) 9 9 2004	32. Registrar	s Signature	Asm &	61				21.	36

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 35438 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2004 Month **Physician** Oct. 24, Ruiz Acevedo 3:45 a ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 18, 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min 1 M 2 F Honduras 57 230-77-1366 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23s or 28a-f show other treumatic event. The Medical Examinar must be multipled at Md. Prince Georges Hyattsville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2265 Lewisdale Drive 20783 Honduras Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2X No Yes, Give 1 Never Married 2 X Married White Honduran 1 XYes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Landscaping Landscaper 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be Rafael Ruiz Leiva Aura Ines Acevedo 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vaneza Alejandra Ruiz-Perla 2265 Lewisdale Dr., Hyattsville, Md. 20783 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State San Pedro Sula, Honduras 20a. Method of Disposition Date *ö <u>=</u> 1

Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Nov. 1, 2004 ö permit. Page Department of Importent: If eny injury or once. Family Cemetery 22. Name and Address of Facility W. H. Bacon Funeral Home, $3447\ 14th\ St.$, N.W. Washington, DC 2001021. Signature of Funeral Service Licenses Inc. Wanda Dycon, Approximate Interval Between Onset and Death 15 hours 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hours Physician Pulmonary Embolus /Medical Due to (or as a consequence of): Examiner 10 Months Stage Four Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medicai the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed? 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Xes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Year) Hospitel or Attending 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lead to be death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) the cause(s) and due to the cause(s). 29a. Certifier Medicai (Check only one) and manner stated. To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 26, 2004 an

Baltimore, Maryland 21215-0036

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Division of Vital Records,

State Registrar

unite eanna 31. Date filed (Month, Day, Year) OCT 2 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



7600 Carroll Ave. Takoma Park Md. 20912

State of Maryland / Department of Health and Mental Hygie 72004 35439 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** OCTOBER ANDERSEN 2004 10:40AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY SUBURBAN HOSPITAL BETHESDA 8. Date of Birth (Month, Day, Year) MARCH 14,1923 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number **Funeral** Months Days Hours 1 X M 2 ☐ F WISCONSIN 81 Director 395-16-1524 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show other traumatic avent, If a Madical Examiner is ust be notified at 1 ☑ Yes 2 ☐ No Director MONTGOMERY CHEVY CHASE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 items 23a 7106 BROOKVILLE ROAD U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. XYes 2 No fYes, Give 1 □ Never Married 2 □ Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 2 3 ♥ Widowed 4 □ Divorced WHITE Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER ELECTRICAL ENGINEERING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY HEIDERER S. B. ANDERSEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an itam 27 is MARK D. ANDERSEN - SON 7106 BROOKVILLE ROAD CHEVY CHASE, MARYLAND 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of thimportant: If its any injury or ot 50 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) LINCOLN CREMATORY 10-23-2004 BRENTWOOD, MARYLAND 22. Name and Address of Facility neral Service HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Efter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death each line Spiration neumania **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Le rebro Voisillas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit uzessi Due to (or as a co. sequence of) burial P.O. Box 68760 Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) _ 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Kincreance an nicer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 29a. Certifier 🕦 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD ()CT. 17. 2004. 10 remocracy Blut, of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address KEDOY Mo 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar 25 2004 OCT

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Registrar

2004

		- For	partment of Health and I ertificate of Death	Mental Hygier	ZUU4 Shaal
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
Physic /Med		Beulah Virginia Boyd		NOVEMBER	1 2004 1945 M
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
*		MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	CUMBERLAND If Under 1 Year If Under 24 Hrs.	8 Date of Birth	ALLEGANY 9. Birthplace (State or Foreign
Funera Directo		217-40-1135 1 M 2 M F 64 Yrs	Months Days Hours Min.	(Month, Day, Yea	ar) Country)
ō.		Usual Residence of Decedent			
show	7	10a. State 10b. County 10c. City, Town or Maryland Allegany Oldton			10d. Inside City Limits 1 ☐ Yes 27 No
the M	ecto	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
3e or	Ö	15601 Frog Hollow Road	21555		ISA
death	Funeral Director		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or items 23e or 28e-f show eumatic event, the Medical Evant are must be notified at	y Fu	1 ☐ Never Married 21X Married 1 ☐ Yes 2 ☐XNo	1 ☐ Yes 2 ☑ No Specify:		Specify: White
hours turel,	d by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation	16b	. Kind of Business/Industry
In 72 n na n na	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of wo b. DO NOT use retired)	rking	
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Pages ent of nt: If i		1 \(\overline{\text{S}}\) Burial 2 \(\overline{\text{Cremation}}\) 3 \(\overline{\text{Removal from State}}\) 4 \(\overline{\text{Donation}}\) 5 \(\overline{\text{Other (Specify)}}\) Glendard	ale Cemetery 5,	ov 2004 F1	intstone MD
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene importent: If item 27 is marked other then any injury or other treumatic event, the Mental Pages.	i	21. Signature of Funeral Service Licensee	22. Name and Address of Facility		D.7
1 88 E 5 8	3	Greates & Hader	1302 National	Hwy, LaVa	le, MD 21502 Approximate
		23a. Part1. Enter the dis. as, or complications that caus. The death. Do not shock, or heart failur: ist only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
Physiciar /Medica	_	disease or condition displayed by the d	PHYLOCOCCUS EPIDER	MIDIS	5 DAYS
Examine		Due to (or as a consequence of):			
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iw requires that s been signed t	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		co use contribute to the cause of death?
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has b	Completed	EMPHYSEMA, RESPIRATORY FAILURE		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
				1 □ Yes 2€	
Ot VICAL Physicien: ' This certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2▼ No Hospital: T Inpatient 2 ☐ ER/Outpa	Othor	ath <i>(Check only one)</i> Home 5 ☐ Residence	6 □Other (Specify)
g Phys er this eral dii	I	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how in	
ttsnding Ph death. ctor: After th y the funeral	atio	2 Accident investigation	M 1 Yes 2 No		
r Atts ter de irecto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
To the Hospitel or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, of	eath occurred at the time, date and place	and due to the cause	o(s) and manner as stated
24 hos Fun etely f	edical	29a. Certifier 1 ★ Certifying Physician: To the best of my knowledge, cone (Check only one) 2 ★ Medical Examiner: On the basis of examination and/cone and manner stated.			
Fo the within Fo the	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		I Mark A	D3548	No.	remberth 2004
X		30. Name and address of person who completed cause oddeath (Item 23a) (Ty		01500	
,		MARK SAGIN, M.D. 600 MEMORIAL AVEN	UE CUMBERLAND, MD	21302	
S Regis	State strar	NOV 0 9 2004	Sports		

			1 - State of Maryland / Department of Health and M Certificate of Death	lental Hygie	*
	Physici		Decedent's Name (First, Middle, Last) CORRINE BROWN	2. Date of Death Month OCt.	Day Year 3 Time by Day 19.2004 9:50 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cheseapeake Hospice House Linthicum		4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 215-18-5228 7. Age (In yrs. last birthday) 87 Yrs. 87 Yrs. 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Mar. 22,	ar) 9. Birthplace (State or Foreign Country) 1917 Virginia
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other then "neturel", or Items 23e or 28e-f show emportant: If item 27 Is marked other then "neturel", or Items 23e or 28e-f show emportant: If item 27 Is marker notified at once.	Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location	ecify Yes or No- Rican, etc.)	10d. Inside City Limits 1 □ Yes 2 □ No Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black . Kind of Business/Industry
d 212	filed with Hygiene ther the	Com		e (First, Middle, Maid	Personal Services
Maryland	Mental I	To Be	Tales Bases	venia –	
	Pnysician /Medical Examiner	Examiner	1 Burial Spicremation 3 Removal from State Cemetery, crematory or other place) 10 10 10 10 10 10 10 1	20c/23/04 Anowden Fon St Ro	Location - City or Town, State
, P.O. Box 68760	faw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	/ Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23a. Did tobacc	23d. Date of delivery Month Day Year co use contribute to the cause of death?
Records,	The law requires ste has been sign page 2 should be	Completed by		1 Yes 24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital	ding Physicien: h. After this certifica funeral director, f	Certification: To Be Co	25. Was case referred to medical examiner? 1	28d. Describe how in	e
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and the time, date and the time, date and the time, date and the time,	red at the time, date	and place, and due to the cause(s)
	Mwith To Con	~	29b. Signature and title of certifier D23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Date signed (Month, Day, Year) O-20-04
			Martin Weltz, M.D. 7525 Greenway Ct., Drive	e, Greenb	pelt, MD 20770
4	Sta Regist				

		A 1.01	partment of Health and Mertificate of Death	•	ne2004	35443
Physic /Medi	cal	Jacob Boon, Jr.	4b. City, Town, or Location of Death	Month	Day Year 2004	11374M
Examir Funeral Director	ner	4a. Fecility Name (If not institution, give street and number) Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 155–18–7742 19 81 Yrs.	Baltimore Cit	9. Date of Birth (Month, Day, Ye 6-18-19	Baltimor Baltimor 9. Birth; Cour 23 N.	place (State or Foreign htry)
vith the Maryland or 28a-f show be notified	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	haels 10f. Zip Code		Citizen of What Coul	1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or Items 23a or 28a-f show may injury or other traumatic event, the Medical Evantiner musibe notified at once.	ted by Funeral Director	1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates: WWII	21663 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify: edent's Usual Occupation	cify Yes or No- Rican, etc.)	JSA 14. Race - Americ Black, White, Specify: Whi	etc. .te
a y failed within 72 should be filed within 72 and Mental Hygiene. Is marked other than "n aumatic event, I'm Media	To Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workii DO NOT use retired) 18. Mother's Name	M. (First, Middle, Maid	leat Supp	olier
s 1 and 2 shou f Health and M item 27 is mar other traumati	1	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mail Bernice C. Boon 247 20a. Method of Disposition 20b. Place of Disposition	ling Address <i>(Street and N</i> um <i>ber or Rura</i> 00 Deep Water Pt	Route Number, Ci	ity or Town, State, Zip	21663
permit. Pages 1 Department of H Important: If ites any injury or ott once.		1 □ Bunal 2 XCremation 3 □ Hemoval from State 1 □ Donation 5 □ Other (Specify) Capito 21. Signature of Funeral Service Licensee	l Crematory 10-2 22. Name and Address of Facility R. Carroll Hurle	y Funer	al Home,	PC
Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the denth Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a		r respiratory arrest	els,Md	Approximate Interval Between Onset and Death
artificate be executed ing physician and e as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.				
that the death certificate ed by the attending physidetached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
w requires that the been signed by the should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
sician: The law s certificate has b lirector, page 2 sl	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed 1 Yes 2 (Check ank ana)	prior to co death?	psy findings available mpletion of cause of
ng Phy After this	Certification: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Stricted 6 Could not be	ont 3 DOA Cther: 4 Nursing Hor of 28c. Injury at Work? M 1 Yes 2 No	ne 5 Residence		
To the Hospital or Attendi within 24 hours after detch. To the Funeral Director: A completely filled in by the ti		4 Homicide determined 229. Place of Injury Articline, fam., s building, etc. (Specify)	th occurred at the time, date and place, a	City or Town, Si	e(s) and manner as s	lated.
To the H within 24 To the Fo completel	Medical	one) and manner stated. 29b. Signature and Mile of certifier	29c, License number	29d.	Date signed (Month,	Day, Year)
<u> </u>	210	30. Name and address of person who completed cause of death (Item 23a) (Type 25a) (Type	ATZ438946 exsity Parkway	Balt	more MO	21218
Regist	ate rar	31. Date filed (Month Day, Year) 32. Registrar's Signature	alle d			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) Month Day Year **Physician** 31, 2004 7:25 AMM Isabelle Graham Mish Bishop Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 24595 Moran Road Hollywood St. Mary's 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Months 1 M 2XXF **Director** 235-28-3854 83 <u>August 1, 1921 West Virginia</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is markad other than "natural", or Items 23a or 28a-f show traumatic evant, Its Madical Examiter must be notified at 1 ☐ Yes 2 XNo Director St. Mary's Maryland Hollywood 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 24595 Moran Road 20636 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: ted by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: if itam 27 is markad of Harry Mish Ruth Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if itam 27 is any injury or other tracence. Harold D. Bishop / Husband 24595 Moran Road Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Joy Chapel Cemetery Nov. 5, '04 Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Tonos 2 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months **Physician** cardio/pulmonary insufficiency /Medical Due to (or as a consequence of) Examiner chronic obstructive pulmonary disease Vost. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner rulmonary interstitial fibrosis Physician: The law requires that the death certificate be executed burial-transit years Due to (or as a consequence of): attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Rheumatoid Arthritis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ineral Director: After this c filled in by the funeral din Certification: To 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attanding 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Thomicide 24 hours a Certifying Physibian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier -29b. Signatur November 2. 2004 gene zzot M. D./physician D02159 10 Am son who completed cause of death (Item 23a) (Type, Priot) 30. Name and address of pg Eugene Guazzo, M.D. 25343 Hurry Road Chaptico, Maryland 20621

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 3 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 35445 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 21 2004 2004 12:50 William Brown ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Montgomery Co. Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 09, 1920 South Carolina 6. Sex 1 → M 2 □ F 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 249-62-0834 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at 1 Yes 2 □ No Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20001 1301 7th Street NW apt. #106 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) 8th College (1-4or 5+) Private Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or othar traumatic event Susie Wesley Brown Unknown Hearmount and SName/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1107 McCullough Ct. NW apt. #103 Wash. DC 20001 Arthor Brown/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Zion Baptist Ceme. Oct. 28, 2004 Bowman, SC 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licensee 716 Kennedy Street NW Washington, DC 20011 23a. Part 1. Enter the disease, or convilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherescleratic Coronary Antry dosec se Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner obstructive Pulmonory dispose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1≱Yes 2□No 1 Inpatient DOA 2 After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Cf (5)

State Registrar

OCT 2 7 2004

UR. JAMES

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 35446 1 = For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Michael Anthony Black Ochenth 25 Day 200 Year 3:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Baltimore, Md 8. Date of Birth Feb. 2 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 SM 2 □ F Wash., D.C. 42 578-80-9123 Usual Residence of Decedent 10b. County DapState. 10d. Inside City Limits Washington 1 X Yes 2 ☐ No 1330 7th Street N.W. apt 408 10g. Citizen of What Country? 10f. Zip Code 20001 U.S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 ☐Xo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Technology Computer Technician 17. Father's Name (First, Middle, Last)
Willle Birdsong Nother's Name (First, Middle, Maiden Surname)
 Margaret Black ^{19a.} Informant's Name/Relationship (Type, Print)
Margaret Black- mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1330 7th St. N.W. Wash., D.C. 20001 apt 408 Nov.2,04 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Landover, Md. Harmony Memorial 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Robinson Funeral Home 1313 6th St. N.W. Rub Wash. D.C.20001 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Plusma cell leukemia 3 yrs disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending

attending physician and for use as the burial-transit The law requires that the death certificate be executed signed by the Division of Vital Records. Michael s certificate has lirector, page 2 Hospital or Attending Physician:

Director: / within 24 hours a

To the Funerel Completely filled

Physician

/Medical

Examiner

Funeral

Director

en "naturel", or Items 23e or 28e-f show Medical Examiner must be notified at

Director

Funeral

2

Completed

Be

Examine

Physician/Medical

2

Completed

Be

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Certification:

Medical

with the Maryland

filed within 72 hours after

I Hygiene.

permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other treumetic event, 90ce.

Physician

/Medical

Examiner

Bull

IF FEMALE

2 Accident

3 Suicide

4 🗌 Homicide

28d. Describe how injury occurred 1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

investigation

6 Could not be determined

D24170

October 25, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. TSO MD

Richey Hospice 838 N. Eutaw St Ballimore, MD 21201

Registrar

31. Date filed (Month, Day, Year) OCT 2 7 2004

29b. Signature and title of certifier



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 2004 35447 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year JOSEPH BURGIN 1444 October 22,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Prince George's Fort Washington Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March Day Year 926 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 241-26-8138 NC Director 78 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itame 23a or 28a-f ehow the Medical Examples must be notified at 1 Yes 2 No Prince George's Fort Washington Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20744 USA 10709 River View Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. No Yes 2 No 1944—
If Yes, Give 1944—
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2√2 No þ 3 Widowed 4 Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Federal Agent permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If Item 27 is marked other any injury or other traumatic avents 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ozzie Keaton Thomas Burgin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley H. Burgin/Wife 10709 River View Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cedar Hill Cemetery | 10/27/2004 | Suitland, MD 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4111 Pernsylvania Ave., Suitland, MD 20746 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Physician /Medical Due to (or as a consequence of): Examiner CARDIOMY OPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burlal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: NIA 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant m the past 12 months?

1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Monatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/23/04 D41182 RI Suite 350 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Livingston Rd ANDERSON Felton 9400 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		-	For State Registrar	State of Ma	ryland		rtment <i>tificate</i>			ınd M		giene Reg. No	11114	35448
	Dhuninis		1. Decedent's Name (First, Middle, Last								2. Date of Dea Month	Day	y Year	3. Time of Death
	Physicia /Medic		NARGIS		GUM						Oct.	1	2004	9:30p [™]
	Examin		4a. Facility Name (If not institution, give	OSPITAL			4b. City, To	(VIL	LE				MONTGO	MERY
	Funeral Director		5. Social Security Number 6. Security Number 10	x 7.Age ∃M 2☐XF 7.Age	(In yrs. las.	t birthday) Yrs.	If Under 1 Months	Days	Hours 1	Min.	8. Date of Birt (Month, Day 4 - 3 - 3)	h V. Year)	9. Birti Co Pak	hplace (State or Foreign untry) 1 S t a n
	D		Usual Residence of Decedent											
	anylan show	_	Maryland Mont	gomery		rown or Loc rman								10d. Inside City Limits 1 X Yes 2 ☐ No
	he M	ecto	10e. Street and Number	gomery	ue	rillan	10f. Zip C	- Ode				10a Cit	izen of What Co	
	with With Liber	ioi	13208 Country	Ridge Dr			-11	2087	7 4			US		,-
	death	era	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V				gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiens. I Health and Mental Hygiens, tiam 27 is marked other than "natural", or Items 23e or 28e-1 show item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumetic event, the Marical Examinar must be rollified at	by Funeral Director	1 Never Married 2 Married 3 🛣 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 1 N If Yes, Give Year or Dates:	lo		Yes, specif		Specify:	, Puerto I	Hican, etc.)		Black, White Specify: A	sian
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation le completed)		(Give	lent's Usual kind of work	done d	urina most	of worki	ng	16b. K	ind of Business/	Industry
21215-0036	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	1 College (1-4or 5	+)		emake					l	Home	
	be filed tal Hygie d other evant, I	BeC	17. Father's Name (First, Middle, Last)	f D-i-			_				(First, Middle,	Maiden	Sumame)	
Maryland	should be nd Mental I markad o	To I	Mirza Ashra	,							Mirza	011		T- 0-1-1
Mar	d 2 sho th and 7 is mu traum		19a. Informant's Name/Relationship (7 Mirza Naeem Ba		- 1						_	-	antown, State, 2 antown	00074
	s 1 and Health tam 27 othar ti		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name	e of			ate		ocation - City or	,
E	Pages nt: #		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		Nat	iona	l Mem	10.	Pk	10-	23-04	Fai	lls Chu	urch,Va.
Baltimore,	permit. Pages 1 and Department of Health Importent: if item 27 any injury or other tr		21. Signature of Funeral Service Licen	Mat	111	4	Name and	Addres nne	s of Facility	yUni St,N	versal .W.,Wa	l II	I Morti ,D.C. 2	uary Inc. 20011
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	lications that caused one cause on each lin	the death.	Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	R V	Immediate Cause (Final disease or condition resulting in death)	a. met		ati	<u> </u>	_e`	n	al	Ca	110	PV	12egv
	/Medical Examiner			Due to (or as	a conseque		Di		ter		Lail	~ 1 ~	-	5dq p
1)	र्ग्स	Jer	Sequentially list conditions, If any, leading to unmediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a doviseque	ried of):	P	400	-	7	9 411			
	rcuted nd transit	Examiner	that initiated events	e 1-1-	791		5113	10	9					
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a conseque		`	N	115	, 6.	٥ ر			
687	certificate Iding physise as the	edical		d	-									
Вох	eath certific attending pt for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	gnancy					23d. Date of del Month	ivery Day Year
Ю.	0 0	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	th 5□	Other (spe	cify)					WOILI	ouy rour
<u>α</u>	requires that the deen signed by the nould be detached		Part II. Other significant conditions of	entributing to death be	ut not resulti	ing in the u	nderlying ca	use give	en in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
rds	quires an sigr uld be	ed by	97/1	ma							1 🗆 '	Yes 2	No 3□Pr	obably 4 Unknown
ecords,	as b	ompleted	due.	mia							24a. Was autor	SV	24b. Were at	stopsy findings available completion of cause of
\propto	Th ate pag	Соп									perfo 1 ☐ Yes	rmed? 2 No	death?	2100
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	005	2/0		_ Othe	20		(Check only o		2 F0: (2	
o		To To	1 ☐ Yes 2 → No 27. Manner of Death	28a. Date of Inju (Month, Da)		R/Outpatier	NAME AND ADDRESS OF THE OWNER, TH	Bc. Injury	at at		me 5 □ Hesid 28d. Describe		6 □Other (Special of the control of	city)
ion	C = =	atior	Natural 5 Pending 2 Accident investigation		/ rear)	Injury	М	Work 1 □ \	Yes 2	No				
Division	after de Diracto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc	ury - At hom c. (Specify)	ne, farm, str	eet, factory,	office			28f. Location (3 City or To			aral Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best liner: On the basis of and manner sta	examinatio	ledge, deatl on and/or in	n occurred a vestigation,	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s date an) and manner as d place, and due	stated. to the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of certifier						number				ite signed (Monti	
	1		I lind can					DI	4110	5 L	UD (5 C	tchev:	222004
			30. Name and address of person who	completed cause of d ND / q	eath (Item 2	23a) (Type,	Print)	cs.	Di	٧٢	6011	nan	trung	D20874
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 25 20	/ /	ar's Signatu	re L	Spa	reks	/					

		For State Registrer	State of Maryla		artment of F			Reg. No. UU4	35449
Physicia /Medic		1. Decedent's Name (First, Middle, La Marjorie	W.	Bi	nley			22, 2004	4:47 P M
Examine Funeral	•	4a. Facility Name (If not institution, giv Charles Co. Nursi 5. Social Security Number 6. S	ng & Rehab Ce	nter . last birthday,	LaPlat	If Under 24 Hrs.	8. Date of Birl	4c. County of Dea	S
Director		236-36-0482 Usual Residence of Decedent 10a. State 10b. County	□ M 2 X F 78	Yrs.	Months Days	Hours Min.	Feb. 19	9, 1926 0x	ley, WVa
h the Mary or 28a-f sho	irector	MD St. Ma	ry's N	<u> 1echani</u>	csville 10f. Zip Code			10g. Citizen of What C	1 ☐ Yes 2√ No country?
	by Funeral Director	29746 Skyview 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 NiDivorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	20659 Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 No		pecify Yes or No o Rican, etc.)	U.S.A. 14. Race - Am Black, Wh	ite, etc.
within 72 hou ane. than "natura	Completed	(Specify only highest gra	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor d)	king	16b. Kind of Business Hope Cente	•
aryiana A should be filed nd Mental Hygin markad other umetic avant, II	To Be Co	17. Father's Name (First, Middle, Last, Basil G. Worle)		Keji	ab courise	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	er .
Te, Mar 1 and 2 sho Health and tam 27 is m		19a. Informant's Name/Relationship (Jamie Brinkley - 20a. Method of Disposition	Daughter	2974	16 Skyvie	w Dr., Me		ville, MD 20c. Location - City of	20659
DallIMOTE, permit. Pages 1 an Department of Heal Important: if itam 2 any injury or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licentees)	w Ari	lington	matory or other place National 2. Name and Address Huntt Fur	Cemeter ss of Facility	ý	Arlington,	VA
Physician /Medical Examiner		23a. Pav. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause on each line. a	ni'A	Huntt Fur P.O. Box ter the mode of dyin				Approximate Interval Between Onset and Death 1 WCCK
ate be nysicia he bur	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cause of Cause Cause of Cause o	cDue to (or as a conse						
a death he atter	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (<i>specify</i>)	,		23d. Date of de Month	olivery Day Year
8 <u>6</u> 8	by P	Part II. Other significant conditions of Congestive Items	ontributing to death but not re	sulting in the u	inderlying cause give	en in Part I.		obacco use contribute t	o the cause of death?
The law The law ate has b	Completed	Coxon Any ARC Chronic OBStr	trey Disen	rse nonmy	D'se	ASE	1 ☐ Yes	prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of
Phy Phy all this all d	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatio	Hospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatie	f 28c. Injury Work	er: 4 Nursing H		ne) dence 6 □Other (Spe now injury occurred	acify)
To the Hospitel or Attending Phylipin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	eify)			City or Tow		
tha Hosp thin 24 hou o tha Funal	Medical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exer	ysician: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my of	pinion, death occu	rred at the time, o	cause(s) and manner a date and place, and du	e to the cause(s)
F ¥ F 8		30. Name and a dress of pers who	complet- d cause of death (Ite	em 23a) (Type,		4436		october 2	
Star Registra		Dr. Ashvin Patel	M.D., 102 P 2004 32. Resistrar's Sign	aul Mel	lon Court	t, Suite	102, Wa	ldorf, MD	20602

		-	For State Registrar	State o	f Marylan	•	artmen rtificat			ind M	R	leg. No.	004	35450
	Physicia		1. Decedent's Name (First, Middle								2. Date of Dea Month OCTOBER	Day	Year 2004	3. Time of Death 11:55PM
	/Medic Examin	al -	FRANCIS C. CO. 4a. Fecility Name (If not institution)		mber)		4b. City,	Town, or	Location o	f Death	OCTOBER		nty of Death	11:33PM
	Examin	er	TALBOT HOSPICE	-				EAST	ON			T	ALBOT	
	Funeral Director		5. Social Security Number 214–32–5880	6.Sex 1X∆M 2□F	7. Age (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day MAY 7,	(Year)	Coun	lace (State or Foreign try) YLAND
7			Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						11	0d. Inside City Limits
Mon	death with the Marylaho ms 23e or 28e-f show fmust be notified at	tor	MD	TALBOT		EASTO	N							1 ☐ Yes 2 🔀 No
4	or 288	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Coun	try?
4	23a	rai	31171 MATTHEWS			0 10			601	-i-2 (C-	ait. Van au Na	14.5	Race - Americ	USA
0	or Ite	by Funeral Director	11. Marital Status 1 ☐ Never Married	Armed F	2 🗆 No		was Deced If Yes, spe- 1 ☐ Yes		Specify:	, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
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Mary	s 1 and 2 should t Health and Men tem 27 is marke other treumatic	-	19a. Informant's Name/Relations	hip (Type, Print)			•				al Route Numbe			Code)
e, e	t Health item 27 other tr		LENA MARIE S. C	OLE/WIFE	20b. F	3117 Place of Dispo			STOWN		, EASTON		21601 on - City or To	wn. State
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g T			JOHN R.	MERCE			200 S.	_HAB	RISON	IST	N & NEWN EASTON	$-MD_2$	1601	
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	70 ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseq	uence of):	1	20-1					7	
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	ne death certificat the attending phy thed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregna birth 2 Feta pnant at time of conown	il death 3	⊒Ectopic p ⊒ Other <i>(s)</i>					23d.	Date of delive Month	ery Day Year
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Vital	ysicien: The l is certificate ha director, page	Be	25. Was case referred to medica examiner?	Hospital:				Oth-	00		h (Check only o			
6		-T	1 Yes 2 No 27. Manner of Death	11	Inpatient 2	ER/Outpatie		28c. Injun	4 🗆 140		ome 5 Resid			W) HOSPICE
on	ding After fune	ition	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Mo	nth, Day Year)	Injury	м	Wor	k? Yes 2□	No				
Division of	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 200. Flat	ce of Injury - At h ding, etc. (Speci		treet, factor	y, office			28f. Location (S City or Tox	Street and Ni vn, State)	umber or Rura	i Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in I	Medical (29a. Certifier 1 Certifyir (Check only one) 2 Medicel	ng Physicien: To the Exeminer: On the and ma	ne best of my kno basis of examina nner stated.	owledge, dea ation and/or in	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ith occur	red at the time,	date and pla	ce, and due to	the cause(s)
	To the To the comp	Ž	29b. Signature and title of carific	50	MI		29	c. Licens	e number	re	7	29d. Date sig	gned (Month,	Day, Year)
			30. Name and address of person					- (9				1		
			ROBERT B. SANCI		508 IDLI Registrar's Sign		AVE.	EAST(ON, M	D 21	601			
	St Regist	ate trar	UCI 202		A.	Ages					<u> </u>			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER Day 19 **Physician** 2004 7:45AM M MALITA HOPE COLEMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7900 QUAKER NECK RD. BOZMAN TALBOT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | JULY 16 1927 Birthplace (State or Foreign Country)
 NEW JERSEY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2ĀF 77 Yrs. 147-20-6375 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28e-f show other treumatic event, the Modical Examiner must be routflied at YXYes 2 □ No Director BOZMAN TALBOT10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21612 USA 7900 QUAKER NECK RD Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Specify: WHITE Š 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) COMMERCIAL FISHERMAN SEAFOOD 12 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARTHA BAUMGERTER ڡ JOSEPH KREUDL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1441 ST. GEORGE AVE., APT 33, COLONIA NJ 07067 BARBARA A. EPSTEIN/NIECE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Importent: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 10-22-2004 EASTON, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph m. Ostnowski C.F.S.P. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and use as the burial-P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached 9 Unknown à s been signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the irector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 2 No 4 ☐ Nursing Home Residence 6 ☐ Other (Specify)
t 28d. escribe how injury occurred 2 ER/Outpatient 3□ DOA ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Medical Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D60300 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name ar 1013 S. Talbot ST Suite 3 Simulaels MO21663 JA 32. Registrar's Signature 31. Date filed (Morifi, State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Erick Lamont Capers 23, Oct. 2004 11:18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Cheverly Prince George Prince George Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F 37 Yrs. 1967 Washington, DC Director 578-92-0171 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f abov other traumatic event, It a Modical Examination must be notified at ty Yes 2 □ No Upper Marlboro Directo Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10708 Mt. Lubentia Way 20774 USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc filed within 72 hours after 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 Is marked other than Facility Cook 2nd Genesis 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be figured Mental H Lucy Mae Browder Arthur R. Capers, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 10708 Mt. Lubentia Way, Upper Marlboro, MD 20774 Lucy Mae Browder/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages in Department of Himportant: If Ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet. Cemetery 11/01/04 Cheltenham, MD * 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service 6500 Allentown Rd, Camp Springs, MD 20748 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a o. 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 2 0 3 Probably 4 Unknown 1 Yes been sign Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No page 2 s has certificate 1 ☐ Yes Division of Vital director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 1 Natural 28a. Nate of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred After t Certification: or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 💋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier 9 30. Nan e and addre s of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, James Catevenis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		-	For State Registrar	State of Maryland	/ Depa <i>Cer</i>	rtment <i>tificate</i>	of Healt <i>of Dea</i>	h and M th	ental Hygi	iene g. No.	04	35453
X	Physici /Medic		Decedent's Name (First, Middle, Last) VANETTA H. CI	LAY					2. Date of Deatl Month OCTOBER	Day	Year 004	3. Time of Death 4:48 A M
	Examin	er	4a. Fecility Name (If not institution, give st Prince George's I 5. Sociat Security Number 6. Sex	Hospital 7. Age (In yrs. last	t birthday)	tf Under 1	Chever	1y der 24 Hrs.	8. Date of Birth (Month, Day,		nce G	eorge 's
9500-c	be filed within 72 hours after death with the Maryland data hygiene. Id other than "natural", or items 23a or 28a-f show an event, Ite Medical Examination and items 23a or 28a-f show an event, Ita Medical Examination and items 23a or 28a-f show an event, Ita Medical Examination and items 23a or 28a-f show an event.	ed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County DC 10e. Street and Number 4245 Meade Street	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No ti Yes, Give Year or Dates:	13. V	on,DC	20 nt of Hispanic Cuban, Mex	0019 : Origin? (Specican, Puerto	February	Og. Citizen of U.S.	What Cour • A • ce - Americ ck, White, fy: B1	an Indian, etc. Lack
maryiand 21215-	d 2 should th and Men 7 is marke treumatic	To Be Completed	(Specify only highest grade Elementary/Secondary (0·12) 17. Father's Name (First, Middle, Last) Van Horne Murray 19a. Informant's Name/Relationship (Typ.	College (1-4or 5+) 4 yrs	(Give life. L	kind of work DO NOT use Laims	done during retired) Examin 18. M Mi Street and Nu	other's Name nerva umber or Rura	Rice Al Route Number, Washing	Go Maiden Sumar City or Town	overni ne) , State, Zip	ment Code)
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 eny injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral services ense	emoval from State Arl	ingto		er place) Lona1 Address of F	11/ acility J.	4/2004 B. Jenk Landove	ins Fu	ton,V neral	irginia Home
8/60,	Luysician and // Medical Examiner and the burial-transit	dicai Examiner	23a. Peat Enter the disease of complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Deader or injury that initiated events resulting in death) Last	Due to (or as a consequer	I Ble nce of):		of dying, such	n as cardiac c	or respiratory arre	est,		Approximate Interval Batween Onset and Death
O. Box 6	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3□	Ectopic pred Other (spec				[ate of deliver	ery Day Year
ords, P	The law requires that ate has been signed b page 2 should be deta	۵	Part II. Other significant conditions con Multiple Mye	tributing to death but not resulting 10 to the suiting 10 to the s	ng in the ur	nderlying car	ise given in P	art I.	1 □ Ye	s 2X No	3 Prob	ne cause of death?
ital Rec	Physicien: The law this certificate has be ral director, page 2 s	Be Completed	25. Was case referred to medical examiner?					Place of Death	24a. Was ar autops perform 1 Yes 2	y ned? X No	prior to cordeath?	psy findings available mpletion of cause of 2⊠ No
Division of Vital Records,	Jing Afte fune	2	1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		VOutpatien Bb. Time of tnjury		Other: 4 [c. Injury at Work? 1 □ Yes		me 5 Reside 28d. Describe ho			")
DIVIS	Hospitel or Attend 24 hours after death Funerel Director: itely filled in by the	al Certification;	3 ☐ Suicide 4 ☐ Homicide 29a. Certifier 1 ★ Certifying Phys	28e. Ptace of tnjury - At home building, etc. (Specify)	edge, death	occurred a	the time, dat	e and place,	28f. Location (Sti City or Town	, State)	anner as si	tated.
D	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	29b. Signature and title of certifier 30. Name and address of person who co	ner: On the basis of examination and manner stated.	n and/or inv	restigation, i	n my opinion, License numl	death occurr	ed at the time, da	ate and place,	and due to	Dey, Year)
1	Sta Regist	ate rar	RUSSELL DAVIS, 31. Date filed (Month, Day, Year) CCT 2 6 2004	M.D. 6900 Geo	rgia .		N. W.	. Washi	ington,	DC 2030	07	

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Gussie Clifford 21, October 2004 12:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariner Health Bethesda Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2\ F Yrs. 062-03-9484 97 New York Director 12/14/1906 Usual Residence of Decedent Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28s-f show miner must be notified at 1 X Yes 2 □ No Funeral Directo MD Montgomery Bethesda Peges 1 and 2 should be illed within 72 hours efter deeth with the I neil of Heelih and Mentel Hyglene.
Int: If them 27 is marked other than "naturel; or fterms 23a or 28e.
Int: If them 27 is marked other than "naturel; or fterms 23a or 28e.
Int or other treumatic event, its Medical Examiner man be notified. 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 5225 Pooks Hill Road Apt. 326 South 20814 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White <u>ک</u> 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Garment 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Samuel Siegel Goldie Feitel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Apt. 326 South
5225 Pooks Hill Rd, Bethesda, Maryland 20814 19a. Informant's Name/Relationship (Type, Print) Ileana Fleishman, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of important: if it eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 10/22/04 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 4 m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Ischemic Cardiomyopathy Examiner Due to (or as a consequence of) Physician/Medical Examiner Pneumonia ettending physicien end for use as the buriel-trensit Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should be detec Š Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No effer deeth.

Director: After this certific
d in by the funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🔯 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ò To the Hospital of within 24 hours of To the Funeral D completely filled I TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) moun D27660 October 22, 2004 Rang 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Alpana Goswami 11119 Rockville Mike, Ste. 100, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25 oacks 2004 OCT Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth OCTOBER **Physician** STEPHEN ERICK CAPERS 23 2004 5:25 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CIVISTA MEDICAL CENTER LA PLATA, MD CHARLES Hours Min. 8. Date of Birth Month, Day, Yeer) OCT 5, 1958 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1√2 M 2□ F 191-52-6364 France Director Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Charles Pomfret 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8680 Lowell Road 20675 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Electric Power Elementary/Secondary (0-12) College (1-4or 5+) Electrician 12 Business 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be 28 Mental Pages 1 end 2 should nent of Health end Mer ပ Clarence Capers Anny M. Aufrere Capers Department of Health end Important: If Item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Jacqueline F. Capers (wife) 8680 Lowell Road Pomfret, MD 20675 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methodrof Disposition 20c. Location - City or Town, State 1 ☐ Byrial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 10-30-04 Waldorf, MD 5/☐ Other (Specify) 22. Name and Address of Fecility Eberwein Funeral Services 21. Signature of Fu eral Service Licenses M00173 4433 White Pls. La. White Pls., MD 20095 Enter the disease, or commerciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) . ACUTE creatitis MAKNOWN Examiner Due to (or as a consequence of) Physician/Medical Examiner ACUTE tallure LINKKYOWA or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Synorone Adult UN KNOWN Due to (or as a consequence of) resulting in death) Last ACUTE UN KNOW Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cohol ABUSE Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 11 1465 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No edical Certification: To npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-0026262 erson who completed cause of deeth (Item 23e) (Type, Print)
SAMUEL J, MD 11711 LIVINGSTON RD FORT WASHINGTON MD 20744

Registrar **DHMH 16 Rev 6/95**

State

30. Name end eddress of person KLEIMAN, SA 31. Date filed (Month, Day, Year)

OCT 2 5 2004

Division of Vital Records, P.O. Box 68760,

32 Registrer's Signature

BUS-

			1 - For State Registrar			Maryland	-	artmen rtificat					eg. No.	04	35456
	Physici	an	Decedent's Nam	e (First, Middle, Las	^{t)} e Elizabet	h Diamie						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give			1	4b. City,	Town, or	Location of	of Death	October	27, 200 4c. Count	ty of Death	1:50 P
	LXUIIII		Asbury	Health Care					omons				Calv	ert	
-	, Funeral.		5. Social Security N		9x 7. □ M 2 X F	Age (In yrs. It		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day)	-	place (State or Foreign
	Director		154-07-312 Usual Residence o	.1.	LIWI ZUALI	96	Yrs.					Oct. 22,		Ita	
	ow see		10a. State	10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Man Be-f sh	ţo	Maryland	St. Mary's		Gre	at Mil	ls							1 ☐ Yes 2 🗶 No
	or 28)ire	10e. Street and Nu	mber				10f. Zip	Code				0g. Citizen of	What Cou	ntry?
	ath w	ral	45453 Ston	ey Run Driv					634				USA		
9500	within 72 hours after death with the Maryland iene. Then "neturel", or Items 23e or 28e-f show the Medical Examinar must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Marr 3 ੱ Widowed	ried 2 Married 4 Divorced	12. Was Decede Armed Force 1 ☐ Yes 2] If Yes, Give Year or Date	es? K) No		1 ☐ Yes	2 No	Specify:		ecify Yes or No- Rican, etc.)		ice - Ameri ack, White, ify: Wh i	etc.
7	ithin Den Nen	Completed	(Special Special 15. Decedent's Ec cify only highest gra ondary (0-12)		or 5+)	(Give life.	dent's Usua kind of wo DO NOT us ress Ma	rk done d se retired	ation furing mos)	t of work	ing	16b. Kind of E		dustry	
3	12 should be filed w n and Mental Hygier Is marked other ti raumatic event, th	To Be (17. Father's Name	(First, Middle, Last) romonte						_	er's Name • Gurg	e (First, Middle, gigno	Maiden Suma	me)	
lar	s 1 and 2 should of Health and Men tiem 27 is marke other traumatic			ame/Relationship (7 na D'Aria/ ;								Al Route Number		, State, Zip	Code)
a,	1 and Health em 27 ther t		20a. Method of Dis			20b. Pl	ace of Dispo	sition (Nan	ne of	1		Mills, M	D 20634 20c. Location	. City or Tr	num State
_			1 🗶 Burial 2	Cremation 3		ate Ce	emetery, cre	matory or o	ther place	!					
	그 든 윤 글			5 □ Other <i>(Specif</i>) une val Service Li cen		Ced	ar Hill 22	2 Name an	d Addres	s of Facilit	v	2004	East Mi	.11ston	e, NJ
ñ	Departing any ir		Tyle	- in	rong		- 89	Mattin	gley-	Gardin	er Fu	neral Homowood, MD	e, P.A. 20650		
	nysician /Medical Examiner	ner	23a. Parf1. Enter to shock, or head immediate Cause disease or condition resulting in death) Sequentially list confirm any, leading to in cause. Enter Unce Cause (Disease or Cause) (Disease or Cause)	onditions,	a	as a consequ as a consequ	Head ience of): Atended of):	+ F	a. Ju	e t	cardiac (or respiratory arr	est,		Approximate Interval Between Onset and Death
,00/00	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	edical Examiner	Cause (Disease or that initiated events resulting in death)	s 📰	C. Due to (or	as a consequ	Induction of the second of the	5.	teno	2/ 2					
.O. DOX	it the death certific by the attending p tached for use as it	Physician/Medical	IF FEMALE: 23b. Was deceden in the pasl 12 1 ☐ Yes 24 9 ☐ Unknown	months?		n 2 ☐ Fetal tat time of de	death 3[⊒Ectopic pr ⊒ Other (sp						ate of delive onth	ery Day Year
Jus, r	w requires that been signed I should be det	by	Part II. Other signif	ficant conditions of	ontributing to deat	h but not resu	lting in the u	nderlying c	ause give	n in Part I.		23e. Did to			ne cause of death?
C	The ate h page	Completed										24a. Was a autops perform	y ned?	prior to con death?	psy findings available mpletion of cause of 2 No
1	Physicien: 1 this certificat ral director, p	o Be	25. Was case refer		Hospital:	ation: ST	-D/O		Othe			(Check only on			
5	ing the contract of the contra	-	27. Manner of Deat 1 ✓ Natural 2 ☐ Accident	th 5 Pending investigation			ER/Outpatier 28b. Time o Injury		Bc. Injury Work	at Nu		me 5 □ Reside 28d. Describe ho			γ)
DIVISION		Certification:	3 Suicide 4 Homicide	6 Could not be determined	building,	, etc. (Specify,)					City or Town	, State)		l Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Discompletely filled in	edical	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medicel Exam	ysician: To the be liner: On the basis and manner	s of examinati	vledge, deatl ion and/or in	h occurred a vestigation,	at the tim in my op	e, date an inion, deal	d place, a th occurr	and due to the ca ed at the time, d	iuse(s) and m ate and place,	anner as si and due to	ated. the cause(s)
	o the vithin o the omple	Mec	29b. Signature and	I title of certifier)	Juitou.		29c	. License	number		2	9d. Date signe	ed (Month,	Dey, Year)
	- 5 - 5		1 2	2-1/1	Tank	our c		,	24	761	0				2004
6	AC		30. Name and addr	ress of person who	completed cause of	of death (Item	23a) (Type,	Print)							, 607
	6			ardio, MD,					310	Prin	Ce E	rederic	MD	20679	2
ŀ	Sta Registi		31. Date filed (Mon	NOV 0	32. Regi	ismar's Signati	ure	Acres		********	.c c f	100011C	·, rii).	-=	

Jame RJD	s Davis	S,	Pleas 1 - For State	se Type or P State of	rint in Bl Maryland	/ Depa	artment of	Health	and N	II Copies Mental Hy	giene	gible.] N L	35457		
	Physicia	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. James Davis, III 4a. Facility Name (If not institution, give street and number)					rtificate c	or Deat	n	2. Date of Do	Day	Year	3. Time of Death		
	/Medica					Π	4b. City, Tow	n, or Location	n of Death		r 22, 2	nty of Dea	1533P. M		
	LAdillile	•	Prince Georges				Cheve						eorges		
	Funeral Director		5. Social Security Number 577–82–4095	6. Sex 1 ★ 2 F	Age (In yrs. las 27	st birthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Bi (Month, Di 3/22/	rth a <i>y, Year)</i> 77	9. Birt	thplace (State or Foreign country)		
3	3 33 4		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation						10d. Inside City Limits		
Mood	of sho	jo	D.C.			ashino							1 Yes 2 No		
i č	28	ired	10e. Street and Number				10f. Zip Cod	е			10g. Citizen o	of What Co	ountry?		
4	23e (aic	240 34th St	.,S.E. # 4				200	19		U	.S.A.			
5-0036	"neturel", or Items 23e or 28e-f show	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force ed 1 Tyes 2 If Yes, Give Year or Date	es? [★No	1	Was Decedent of Yes, specify C			pecify Yes or No Rican, etc.)	0- 14. R B Spec	lack, Whit	erican Indian, le, etc. Black		
5-0036	"neturel",	eted	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece	dent's Usual Oc kind of work do	cupation	ost of work	kina	16b. Kind of	Business	Industry		
2121	Department of Health and Mental Hygiene Importent: If Item 27 Is marked other than "any injury or other treumetic event, Item Magnee."	Completed	Elementary/Secondary (0-12)	College (1-4		life.	oo NOT use re	rired)		9	Recv	clino	ī		
Dd 2	other other	Be C	17. Father's Name (First, Middle, I	Last)			220 2000		ther's Nam	e (First, Middle			1		
Maryland	Menta arked etic et	TOE	James Garlar	nd Davis, J	ſr.					e Brown					
Mar	h and 7 Is m reum		19a. Informant's Name/Relationsh							ral Route Numb					
, ie	Health em 2 ther		Marie Brown/ Mc												
Baltimore,	y or o		Marie Brown/ Mother 240 34th St. S.E. # 4, Washington D.C. 20019 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Date 20c. Location - City or Town, State												
altir	orten injur	ļ	21. Signature of Funeral Service L		Стег			dress of Fac		Sons Co.		jton,	D.C.		
ä	Depa Impo any i		Darry	W. S	7 als					,N.E.,V		C	20019		
	-		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death.	Do not ent	er the mode of	tying, such a	as cardiac	or respiratory a	rrest,		Approximate Interval Between		
	hysician /Medical xaminer	1	Immediate Cause (Final disease or condition resulting in death)	-aM			GUN	SMUT	W	OUNP_	7		Onset and Death		
		ulner	Geque Italy liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	h Due to (or	as a conseque	nce of):									
760,	/sician and	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
687	g phys	edic		0.											
Box	ed by the attending physis detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pregna Other (specify,					23d. Date of delivery Month Day Year						
	igne be o	2 Part II. Other significant containous contributing to death but not resulting in the underlying cause given at Part I.							t I.	23e. Did 1	100		the cause of death?		
Records,	ate has bee	Completed								24a. Was auto perfo		prior to death?	itopsy findings available completion of cause of		
of Vital	certificate	Be C	25. Was case referred to medical examiner?					26. Pla	ce of Deat	h (Check only					
of Vita	this ce al dire	0	1 XYes 2 □ No	Hospital: 1 _ Inp	1	NOutpatien	1 3 DOA		Nursing Ho	ome 5 Resi			cify)		
Division o	death. ctor: After this y the funeral di	cation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	ation Iulz 2	Injury Day Year)	8b. Time of Injury		ijury at Vork? Yes 2	Y 00	28d. Describe	how injury occi		SHUT		
5	within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could n 4 Homicide determi	and 286. Place of	Injury - At hom , etc. (90 sity	e, farm, str KIN	eet, factory, office	28		28f. Location (City or To	Street and Num	iber or Ru	IESUTA AND		
] legical	within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier 1 Certifying (Check only one)	g Physician: To the be Examiner: On the basi and mann	s of examination	edge, death n and/or inv	occurred at the restigation, in m	time, date a y opinion, de	and place, eath occur	and due to the red at the time,	cause(s) and r date and place	nanner as , and due	stated. to the cause(s)		
t t	To the compl	Me	29b. Signature and title of certifier	1	/			ense numbe	Г		29d. Date sign				
)	5							Octobe	tober 23, 2004						
R	(2)		30. Name and address of person a	no completed cause	of death (Item 2	3a) (Type,	Print) 111	Penn	Stree	et, Bali	timore,	Mary	yland 21201		

State Registrar

31. Date filed (Month, Day, Year)

OCY 2 7 2004



			State of Maryland / Depa		lental Hygier	ne
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) HATTIE L. DAVIS 4a. Facility Name (If not institution, give street and number) DOCTOR'S COMMUNITY HOSPITAL	4b. City, Town, or Location of Death LANHAM	2. Date of Death Month	No.2004 35458 3. Time of Death Year 4c. County of Death PRINCE GEORGE'S
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 577-22-0718 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea May 1 19	9. Birthplace (State or Foreign Country) Caroline
	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. is marked other then "natural", or iteme 23e or 28a-f show aumatic event, If e Medical Extrainment as the notified at	al Director	10a. State	10f. Zip Code		10d. Inside City Limits 1\(\)\(\)\(\)\(\) Yes 2 \(\)\(\) No Citizen of What Country? ■ S • A •
9000	hours after deatl tural', or iteme 2	ed by Funeral	1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	As Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
d 21215-0036	filed within 72 P Hygiene. ther then "nati int, ILe Modici	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of worki O NOT use retired)	ng 16b.	Kind of Business/Industry PRIVATE
Maryland	s 1 and 2 should be if Health and Mental I item 27 is marked or other traumatic eve	To Be	GEORGE BYNUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	ELLA G Address (Street and Number or Rura	BARNES	y or Town, State, Zip Code)
Baltimore, N	1 and Health em 27 ther tr		20a. Method of Disposition 20b. Place of Disposi	ition (Name of atory or other place)	oate 20c.	y, Maryland 21771 Location - City or Town, State ITLAND, MARYLAND
Balti	permit. Pages Department of the Important: If its any injury or of once.			Name and Address of Facility J. 74 Landover Road	B. JENKIN Landover,	NS FUNERAL HOME Maryland 20785
	Physician /Medical Examiner	_	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Proven	respiratory arrest,	Approximate Interval Between Onset and Death
9760,	ate be executed hysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c			
O. Box 68	it the death certifica by the attending ph tached for use as th	Physician/Med		Ectopic pregnancy Other (specify)	į	23d. Date of delivery Month Day Year
Hecords, P	The law requires that ite has been signed b bage 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the und	ferfying cause given in Part I.		o use contribute to the cause of death?
Vital Rec	10 12	e Completed	25. Was case referred to medical	20 Plant (David	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ISION OF VI	ding Phy n. After this funeral d	ertification: To B	examiner? 1	The second secon		6 ☐Other (Specify) ury occurred
DIXIO	To the Hospitel or Attend within 24 hours after deatl To the Funerel Director: completely filled in by the	O	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge, dea	occurred at the time, date and place, a	City or Town, Sta	s) and manner as dated
	To the Ho within 24 h To the Ful completely	Medical	(Check only one) 2 Medical Examinar: On the basis of examination and/or inverse and manner stated. 29b. Signature and title of certifier	stigation, in my opinion, death occurre	ed at the time, date and 29d. D	ate signed (Month, Day, Year) - 23
0	RQ		30. Name and a Moss of person who completed cause of death (Item 23a) (Type, Pr	124566c	cie r	10226
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 7 2004 32 Registrar's Signature	e)		

			1 - For State Registrar	State of M	aryland		artmen rtificat				_	iene g. No.	04	35459
	Physic	ian	1. Decedent's Name (First, Middle, Las	t)		-					2. Date of Deal	th Day	Year	3. Time of Death
7.	/Medi	cal	Lilian H. Cedili		llegas	5					October	21,	2004	12:39 PM
	Exami	ner	4a. Facility Name (If not institution, give						Location			4c. Cou	nty of Death	
	Funeral		Holy Cross Hosp: 5. Social Security Number 6. Se		e (In vrs. la	ast birthday)	If Under		Spri		8 Date of Birth	Mon	tgome	
	Director			□M 2⊠F	7.	**	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Jan. 2,	^{Year)} 1933	Hor	place (State or Foreign ntry) nduras
	p .		Usual Residence of Decedent 10a. State 10b. County		10. 07	-								
	Aarylan F show	5		2021		Town or Lo							1	10d. Inside City Limits 1 ☐ Yes 2 🐴No
	the A	Director	Maryland Montgor 10e. Street and Number	mer y		Silver	Spri 10f. Zip				1	0g. Citizen o	of What Cou	
	ath with the Maryla 123a or 28a-f shov ust be notified at	i D	12122 Veirs Mill	Road				0906	5			og. Oliizon (USA	nuy:
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jical Exertinet out be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	5. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		lace - Ameri	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔯	No						duran	Spec	lack, White,	etc. ite
8	be filed within 72 hours after des ntal Hygiene. od othar than "natural", or frams evant. Ite Madical Ext. all'eff.	ed b	3¾ Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:		16a. Deced	dont's House	I Ossum	tion					
215	within 72 ene. than "na	Completed	(Specify only highest grad	de completed)		(Give	kind of wor DO NOT us	rk done d se retired	lu <i>ring</i> mosi)	t of worki	ng	16b. Kind of	Business/in	dustry
21	filed withi Hygiene. other then	mo.	6	College (1-4or 5)+)	Home	emake	r				Own	Home	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle, M	Maiden Sum	am <i>e)</i>	
Z	should be filed v nd Mental Hygie marked othar t matic evant, IL	L _o	Luis A. Cedill								es Sanz			
Maryland 21215-0036	Pages 1 and 2 should be ment of Health and Ment. ant: If itam 27 is marked jury or other traumatic.		19a. Informant's Name/Relationship (7								l Route Number,			
	s 1 an f Heal ftam 2 other		Luis A. Villegas/ 20a. Method of Disposition	son	20b. Pla	ice of Dispo	sition (Nan	e of		D	Silver S	Spring 20c. Location		
Ę	Grant of A		1 ⊠ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		Gat	e of	natory or of Heave	her place N	9)		per 25			
Baltimore,	permit. Page Department Important: # any injury or once.	'4 Donation 5 Other (Specify) 21. Signature of Funeyal Service Licensee 22. Name and Address of Facility 23. Signature of Funeyal Service Licensee 24. Name and Address of Facility 25. Name and Address of Facility 26. Collins Funeral Home										ng, Maryland		
<u> </u>	8 9 7 8 9		Wille J	128		5	00 Un	iver	sity	BI vo	l, W, Si	lver S	Spring	, MD 20901
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	aThrombo Due to (or as bAtrial Due to (or as	embol a conseque Fibr	ism ence of): illati		or dying	, such as	cardiac o	respiratory arre	isi,		Approximate Interval Between Onset and Death
Box 6	ne death certificate be executed the attending physician and hed for use as the burral-transit	Physiclan/Medical Exa	resulting in death) Last	Due to (or as: d	of pregnance 2 □ Fetal of	cy leath 3	Ectopic pre						Date of delive	ory Day Year
s, P	w requires that the d s been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death bu	ıt not result	ing in the un	iderlying ca	use give	n in Part I.			_		e cause of death?
COL	w req	lete									24a. Was an			osy findings available
	iician: The law certificate has b rector, page 2 sl	e Completed	25. Was case referred to medical						00 Pi		autopsy perform 1 Tes 2	ed? No	prior to cor death?	appletion of cause of
	9 S =	To B	examiner? 1 ☐ Yes 2∏ No	Hospital: 1 ☐ Inpatie	nt 2⊠El	R/Outpatient	3 DO/	_			(Check only one ne 5 ☐ Resider		ther (Specific	*1
	ding h. After fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury		c. Injury Work	at ? es 2 □ N	2	8d. Describe hov	v injury occu	ırred	,
É	Dir	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	: (Specify)						8f. Location (Stre City or Town,	State)		
	Hos Fur ely	edical	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best on ner: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, death	place, ar	nd due to the cau d at the time, dat	use(s) and m to and place	nanner as sta , and due to	ated. the cause(s)
_	To tha within 2 To tha complet	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date sign	ed (Month, L	Day, Year)
1	<)					D469	945			Oct	ober 2	22, 2004
1			30. Name and address of person who co											,
			Titalayo Olutola 31. Date filed (Month, Day, Year)				7,750		Larç	go,ME	20782			
No.	Sta Registr		OCT 2 5 2004	32 Tegistra		19	Spar	KN						

			1 - State Amend Item 25 pe	ite of Marylar er me G839	nd / Dep 1-18- Ce	artment of He 05. tas rtificate of D	ealth and M Death	lental Hygi	ene 004	35460
	Physici	an	1. Decedent's Name (First, Middle, Last)	D:				2. Date of Death Month		3. Time of Death
	/Media	al	Cristobal 4a. Facility Name (If not institution, give street a	Dia	12	4b. City, Town, or I	Leasting of Doub	Oct.2	1 2004 Year	8:04а м
	Examir	er	Washington Advent	•	oital		a Park		Montgo	
	Funeral Director		5. Social Security Number 6. Sex none 1% M 2	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 16	Year) 9. Bin Co , 1960 Ho	thplace (State or Foreign buntry) induras
	yland tow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo					10d. Inside City Limits
	e Mar	ctor	MD Montgomery	Y	Silve	er Spring	3			1 ☐ Yes 2 🔀 No
	ath with th 23a or 28 ust be no	rai Dire	10e. Street and Number 8500 16th Street	# T-6		10f. Zip Code 20910			g. Citizen of What Co Honduras	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "netural", or Itams 23a or 28a-1 show many injury or other traumatic evant, Ira Madical Evanti at must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1 If Y	as Decedent Ever in Uned Forces? Yes 2X No Yes, Give ar or Dates:	1	Was Decedent of His If Yes, specify Cuban 1 ☑ Yes 2 ☐ No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
5-	"netu	ietec	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of worki	ng 1	6b. Kind of Business/	Industry
72	iene iene rthan	omo	Elementary/Secondary (0-12) Col	llege (1-4or 5+)		shwasher			Restaura	.nt
	al Hyg I other vant,	BeC	17. Father's Name (First, Middle, Last)		<u> </u>		18. Mother's Name			
ylaı	ould b Menta	To I	Fidencia Diaz	7-4				a Mejia		
, Maryland	und 2 sh alth and 27 Is m		19a. Informant's Name/Relationship (Type, Pri Elvin Diaz/Nephew	nt)	19b. Mailir 3207	ng Address (Street ar Medway	Street	Route Number, Silver	City or Town, State, 2 Spring,	Zip Code) Md20902
Baltimore,	Pages 1 annent of Herant: If itam		20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Spefity)	I from State	cemetery, cren	sition (Name of natory or other place) dro Cem)			Town State O Comas Ca Honduras
Balt	permit. Departr Importa any inj		21. Signatur Funeral Service Inconsee	•					L SERVIC	E,P.A. g,Md20910
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the deat se on each line.	h. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arres	st,	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	SOP	300					Onset and Death
	Examiner			ue to (or as a consec	uence of):	PCC	e life o	11 0	į.	DV house
	D .=	ner	Sequentially list conditions, it may lead in the manager cause. Enter Underlying Cause (Disease or injury	tie to (or as a conseq	manos of):	0	aryer	N.C.	0	2 9 100000
	ecuter and trans	Examiner	that initiated events c.	oue to (or as a conseq	NZC	2 MS	umé			2 days
8760,	icate be executed physician and s the burial-transit	dicai E	d	Deedl	olis	M	1	MEDICALE	AMINER	2 years
9	ntifical ng phy s as th	Medi	IF FEMALE:			CER	TIEN TOPOROV	EDBY		0.30
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregna]Live birth 2 □ Feta]Pregnant at time of d]Unknown	Ideath 3	Ectopic pregnancy Other (specify)	dii 1		23d. Date of deli Month	very Day Year
s, p	taw requires that the as been signed by the 2 should be detache	by Ph	Part II. Other significant conditions contribution	ig to death but not res	ulting in the ur	nderlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Srd	w require been sig should b							1 ☐ Yes	2 ☐ No 3 ☐ Pro	obably 4 Hinknown
Record	The ate h page	Completed		·				24a. Was an autopsy performe	prior to c death?	topsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			Othor	26. Place of Death	(Check only one)		7000
ō	ding T. After fune	tion: To	1 M 162 2 MO.	Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	t 2	ne 5 Resident 8d. Describe how	e 6 □Other (Specinjury occurred	ify)
Divis	tal or Attending s after death. al Director: After ad in by the fune	Certification	a □ Cuitanda 6 □ Could not be	Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office	2	8f. Location (Stree City or Town,	et and Number or Rui State)	ral Route Number,
	To tha Hospital o within 24 hours at To the Funaral D	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: 2 ☐ Medical Exeminer: On and	To the best of my kno the basis of examina d manner stated.	wledge, death tion and/or inv	occurred at the time, estigation, in my opin	, date and place, a nion, death occurre	nd due to the cau d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To To t	Σ	29b. Signature and title of certifier	. 1 \	0.0	29c. License r	number	29d	Date signed (Month	. Day, Year)
	V	-	- Suxullimil	(, ILID. H	SPITAL	IST D	54381		10/01/0	4
			30. Name and address of person who completed	Cause of death (Item	100 A	NENTIST X	JOSPINAC	7600	Carsollau	enul asoma
	Sta Registr	_	31. Date filed (Month, Day, Year) OCT 2 5 2004	32. Registrar's Signa	ture	South	/		Porte It	61106

			For Stata Registrar	State of Maryla			of Health			giene Reg. N2 N N L	251.61
	Physic /Med		1. Decedent's Name (First, Middle, Las Betty E. Fazer						2. Date of De Month	ath Day Year	3. Time of Death
\$	Exami		4a. Facility Name (If not institution, give MEMORIAL HOSP 5. Social Security Number 6.	ITAL		CUME	own, or Location	n of Death		4c. County of Dea	ath ANY
	Funeral Director			DM 2፟∰F 77	s. last birthday) Yrs.	If Under 1 Months	Days Hours	Min.	8. Date of Birt (Month, Da OCT 13	Y. Yearh	rthplace (State or Foreign Sountry) t Virginia
	death with the Maryland ma 23a or 28a-f show	Director	10a, State West Virginia Miner 10b. County Number		Ridge.		ode			10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2√ No
	death with	Funeral Di	Rt 2 Box 227F	12. Was Decedent Ever in I	J.S. 13 V	26	753	rigin? (Spe		USA	
9000	ours after oursel, or Itan	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify			ecify Yes or No- Rican, etc.)		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked othar than "natural", or Itama 23a or 28a-f show any Injury or other traumatic event, the Medical Evant act most be notified at once.	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+)	(Give	lent's Usual (kind of work DO NOT use tor/C	Occupation done during mo retired) Office	ost of worki Mana	ager	Real Est	,
Maryland	hould be fill d Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Charles M. Phi 19a. Informant's Name/Relationship (7		40, 11, 15		Gen	eva	E. Ada		
	s 1 and 2 s f Health an ftam 27 is s other traus		William Fazenb 20a. Method of Disposition	aker,Jr-Hus	band F	Rt 2 I	Box 22	7 F, R	idgele ate	r, City or Town, State, Y, WV 267! 20c. Location - City or	53
Baltimore,	permit. Page Department o Important: If any Injury or once.		1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	stLawr.	natory or other 1. Mem	Garde:	ns	,2004 ervice	LaVale,MI	
m	eg m ma		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	, PA ale, MD 2	21502 pproximate Interval Between						
ē.	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCAI	RDIAL I						Onset and Death 8 HOURS
8760, X	cate be executed physicien and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.							
.O. Box 68	The law requires that the death certificate ite has been signed by the attending physioge 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn; 1 □Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	death 3 □	Ectopic pregr Other (s <i>pecil</i>	nancy (y)			23d. Date of del Month	ivery Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	derlying caus	e given in Part I			pacco use contribute to	the cause of death?
	₩ 4	Completed							24a. Was ar autops perform 1 Yes 2	y prior to death?	topsy findings available completion of cause of
	Phyaic this ce ral direc	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	lospital: 1 ⊠Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		Other	ırsing Hom		e) nce 6 □Other (<i>Spec</i> w injury occurred	sify)
5	ten foat for: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place Trijury - At ho building, Etc. (Specify	ome, farm, stree	М	1 ☐ Yes 2 ☐	-	3f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	edical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the	ne time, date an ny opinion, dea	d place, ar th occurred	nd due to the ca d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
1	To the Nithin 2. To the Complete	W	29b. Signature and title of certifie	12		D36	766			OVEMBER (Month	. Day, Year) 2004
	8		30. Name and address of person who con DR.VIK POONAI 924 31. Date filed (Month, Day, Year)	SETON DRIVE	CUMBE		MARYLAN	D 21	.502	//	
	Sta Registr		NOV 0 9 2004	32. Registrar's Signa	6 4	backs	ý				

			1 - For State Registrar	State of	Marylan		artment rtificate		alth and M eath		giene 0	04	35462
			1. Decedent's Name (First, Middle	, Last)						2. Date of De	ath Day	Yeer	3. Time of Death
	Physici /Medio		Elizabeth	Fulbright	F6	eney				NOVEM		2004	22:04 M
	Examir		4a. Facility Name (If not institution	, give street and numb	oer)		4b. City, T	Fown, or Lo	ocation of Death		4c. Cour	ty of Death	
	5	1	MEMORIAL HOSPI				CUMB:	ERLAN	ID If Under 24 Hrs.		ALLE	EGANY	
	Funeral		5. Social Security Number	6. Sex 7. 1 □ M 2 □ F	Age (In yrs. I	Yrs.	Months		Hours Min.	8. Date of Bird (Month, Da Sep 8,	y, Year)	9. Birthp	place (State or Foreign http)
	Director		218-30-0578 Usual Residence of Decedent		04		l			Sep o,	1920	1	NC .
	yland Mor		10a. State 10b. County		10c. City	, Town or Lo		.1				1	0d. Inside City Limits
	e-1s	ctor	MD Alle	gany 		Cumi	perlan	a 					1 Yes 2 No
	ith the	by Funeral Director	10e. Street and Number				10f. Zip				10g. Citizen o		itry?
	23a	rai	1003 Kentucky						1502			ISA	
	items	nne	11. Marital Status	12. Was Decede	es?	ţ			anic Origin? (Spo Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. H	ace - Americ lack, White,	
36	ir, or	by F	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 ☐ Yes 2 If Yes, Give Year or Date	S:		1□Yes 2	No S	Specify:		Spec	ify: white	e
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or items 23a or 28e-f show ha Madical Examinat must be rodified at	ted	15. Decedent	's Education		16a. Dece	dent's Usual	Occupation	on		16b. Kind of		
215	Pin 7.	pie	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use	e retired)	ring most of work	ing			
C	ed wi	Completed	12	2+	-	Regist	ered N				Hospita		
pu	12 should be filed within " h and Mental Hygiene." 7 is marked other than " freumatic event, the Mes	Be	17. Father's Name (First, Middle,					18	8. Mother's Name			ame)	
7	d Mer narke	ဂ္	Daniel Fulbrig	<u> </u>		10h Mailie	a Addross	/Street end	Hattie \			e State Zin	Cadal
Maryland	d 2 st		William Feeney		1				ry Avenu				21502
	1 and Health tem 27 other tr		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	e of		Date	20c. Location		
ΘL	Pages nent of I ant: ff ite ury or o		1 ☑XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S)			_{emetery, crer} Mary's C			i	11/6/2004	Cumb	erland	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or iteme 23a or 28e-1 show any injury or other treumatic event, the Medical Examinat must be notified at ance.		21. Signature of Funeral Service		1 1 1	<u> </u>			of Facility Funeral Ho	DA			
ä	Per Per Per Per Per Per Per Per Per Per		Camus	7 AIR	$\ell \mathcal{U}$				runerai no nia Avenue		land ME	21502	
	- 101		23a. Part 1. Enter the disease, or shock or heart failure. List	complications that cau	sed the death	. Do not ent	er the mode	of dying,	such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PNEUMO								>	Onset and Death WEEK
	/Medical		resulting in death)	Due to (or	as a consequ	uence of):							-
	Examiner.	L	Sequentially list conditions,	b									
	pe ils	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dicease of it July) that initiated events	Due to (or	as a consequ	ience of):						J	
	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):						_	
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68760	ficate physics the	edic		d.									
ŏ	death certifica a attending ph d for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			Totania and				23d. D	ate of delive	ry
m ·	the atte	icia	in the past 12 months? 1 □ Yes 2 □ No		h 2∏Fetal nt at time of de		Ectopic pre Other (spe				N	Ionth	Day Year
P.O	thet the dead by the detached	Physician/Med	9 🗌 Unknown								//		
S,	es the	by	Part II. Other significant condition DIABETES MELLI		th but not resu	ulting in the u	nderlying ca	use given i	in Part I.				e cause of death?
ord	w requir been si should	ted								1 🗆 Y	es 2 No	3 Prob	ably 4 □Unknown
Records,	e taw i has b	Completed	RENAL FAILURE							24a. Was autop	sy	prior to cor	psy findings available npletion of cause of
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Mosnital:					6. Place of Death				-
of	this al dii	Ţ.	1 Yes 2 PNo 27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of		Sc. Injury at	4 Nursing Ho	me 5 □ Resid 28d. Describe h)
	ding th. After funer	tion	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Month,	Day Year)	Injury	М	lc. Injury at Work? 1 Yes	s 2 No		, , ,		
Division	r Attending er death. rector: Aftel by the fune	ifica	3 ☐ Suicide 6 ☐ Could to	ined 286. Place of	Injury - At ho	me, farm, str	eet, factory,	office				ber or Rura	l Route Number,
Ö	el or A s after of Direct	Certification:	4 Homicide	building	, etc. (Specify	")				City or Tow	m, Statej		
	hour hour unere		29a. Certifier 1 Certifyin	g Physicien: To the be Exeminer: On the basi	est of my know	wledge, death	occurred a	it the time,	date and place, a	and due to the	cause(s) and n	nanner as st	ated.
	To the Hospitel or At within 24 hours after or To the Funeref Direc completely filled in by	Medical	one)	and manner			r						
	To To com	2	29b. Signature and title of certified	-1000			29c.	License no	uinder	:	29d. Date sign	ea (Month, l	ray, rear)
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	Sta	ato.	WILLIAMS, TERRY 31. Date filed (Month, Day, Year)		istrar's Signal		AL AVE	INUE,	COWREKT	AND, MD	21502		
	Registi		NOV 0 9 20	04 Sept	var ,	6	bour	2					

State of Maryland / Department of Health and Mental Hygien 2004 35463 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** OCTOBER VERNON MARSHALL /Medical FLOOK 30 2004 11:11 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth OCT. 14, 1917 Mary Year, 1917 Mary Tand 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1**∑**M 2□F Days Hours 87 217-12-1874 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28e-f show Examination must be retified at 10d. Inside City Limits Maryland Frederick Frederick 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 512 Schley Avenue U.S.A. Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed other treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Brick Layer/ Mason Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Philip Edward Flook Elizabeth Remsberg ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cer 3834 Roundtree Road, Jefferson, MD 21755 19a. Informant's Name/Relationship (Type, Print) Mrs. Darlene M. Kennedy, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Zion Lutheran Cemetery 20a. Method of Disposition

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it eny injury or o Nov. 4, 2004 Middletown, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lin nsee ²².Reenevoorand Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dreumania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be Shorlates 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Caeanar 24a Was an has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check on one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient funeral dir 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1 1 Natural 5 Pending after death. Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 / Homicide within 24 hours a To the Funerel D Textifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WD 056890 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in Diwence antreace 60 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 35464 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2 Dete of Death Physician 25 09 Joshua Wilson Fenwick /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number, 4c. County of Death Examiner SPECIALT UNIVERSITY tUSPITAL Baltimore 6. Sex 12 M 2□ F If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Days 213-22-8004 May 24,1927 Director Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □ Yes 2 No Director Maryland Kent Worton 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number DOSEME WILSON FRANCIA USA 13166 Funeral Jones 21678 Lane 12. Was Decedent Ever in U,S. Armed Forces? 1 MYes 2 ☐ No MYes, Give 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1□ Yes 😾 No Specify 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Fort Lift Driver Vital Foods Depertment of Health and Mantal Hygin Important: If Itam 27 is merked other 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Thomas Randolph Fenwick Abbie Tilghman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Fenwick / wife 13166 Jones Lane, Worton, Maryland 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 09-30-04 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Beenie Smith Funeral Home 717 W. Division Street, Dover,Delaware 19904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ACCIDENT WITH MULTIPLE INJURIES Examine Examine DIABE MELLITUS TES Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) IPERTENSION Box 68760 Physician/Medical Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Tunknown CRTIF ρ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Vec 2000 1 ☐ Yes 2 ☐ No. certificate To the Hospital or Attanding Physician: within 24 hours aftar deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Senpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred Mator VEHICLE 27. Menner of Deeth 28b. Time of Injury 5 Pending investigation 1 Natural AVG 20 2004 12,00 P ACCIDENT COLLISION VISUS TREE 1 Yes 2 No 2 Accident 28f. Location (5 and Number or Rural Route N. mber, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Rt 300 - CHOS TER TOWN, Ma. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier James P. Lynu M.D DO 1346 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) 6015. CHARLES ST. BALTIMORE JAMESP. PLANN. UNIVERSITY SPECIACTY HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

			For State		State o	f Marylar					Mental H	ygier	ne		
		4	Registrer	A 41-4-41- 1			Cei	tificate	of De	eath		Reg. N	2001	251	CE
	Physici	an	Decedent's Name (First)	, Middie, Las							2. Date of D Month	0	Day Year	. Tisher	if Balatta
	/Media	cal	de Carille Name /// get in			lizabet	h Faun				Octob			3:54	P M
	Examir	ner	4a. Facility Name (If not in		street and nui	mper)		4b. City, Te	own, or Lo	cation of Dea	ath	4	4c. County of Death	1	
4			38122 Beach 5. Social Security Number		Y	7. Age (In yrs.	last hirthday)	Coltor If Under 1		n t Under 24 Hr	S O Data of D		Saint Marys		
	Funeral Director		431-40-1763			r. rigo (myrs.	75 Yrs.			Hours Mir	n. (Month, D	ay, Yea	(OL	place (State intry)	or Foreign
			Usual Residence of Deced	ient							January	25,	1929 Arka	nsas	
	yland		10a. State 10b. 0	County		10c. Ci	ty, Town or Lo	cation						10d. Inside C	City Limits
	Mar B-f s	ioi	Maryland Sa	int Mar	ys		Co1to	ns Poir	t					1 🗌 Yes	s 2 ∑ No
	or 28	Director	10e. Street and Number					10f. Zip C				10g. C	Citizen of What Cou	ntry?	
	th wi	a	38122 Beach R	oad					20626				USA		
	ems	ne	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U		Vas Decede	nt of Hispa	inic Origin? (Specify Yes or N	0-	14. Race - Amer		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28e-1 show eumatic event, the Mcdical Examiner must be mailfled at	by Funeral	1 Never Married 2		1 □Yes If Yes, Giv	2 XNo /e		Yes 25		Specify:	ito nican, etc.)		Black, White Specify: Whi		
2-0036	hour turel	ed b	3 ☑ Widowed 4 □ Di		Year or D	ates:	160 Deced	lamble (Januar)	2						
Ċ	in 72 i "na	Completed	(Specify only	-	de completed)		(Give	ent's Usual kind of work OO NOT use	done durii	n ng most of wo	orking	16b.	Kind of Business/Ir	idustry	
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0	filled Hygi other	Ö	17. Father's Name (First, M	Aiddle, Last)				ecretar		Mother's Na	me (First, Middle	a Maide	State Gover	nment	
<u>a</u>	id be ental ked (To Be	William John	Γ∩1and											
3	shou nd M mar	-	19a. Informant's Name/Re		ype, Print)		19b. Mailin	a Address (5			a Josephii Bural Boute Numi		or Town, State, Zij	n Code)	
	nd 2 alth a 27 is r trei		Michael Joseph	h Faunce	e / Son								yland 20659		
ā,	f Heal		20a. Method of Disposition				lace of Disnos	eition (Nama	of		Date		Location - City or T		
Ë	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic esponse.		1 X Burial 2 ☐ Crem 1 Onation 5 ☐ Of			_	emetery, crem			-	mber				
altimore,	artim orter inju		21. Sign Are of Funeral S	, ,		Sac	red Hear	Name and			2004	Bush	wood, Mary	.and	
ä	Der Imp		Muchael	Luce .	Trade	V	Ma	ttingle	v-Gard	iner Fu	neral Home	, P.	A.		
	- A		23a. Part1. Enter the dise shock, or heart failure	se, or come	lications that c	aused pe deat	h. Do not ente	or the mode	of dying, s	uch as cardia	c or respiratory	arrest,	20650	Approxima	te
	Physician		Immediate Cause (Final	e. List only o										Interval Be Onset and	tween
	/Medical		disease or condition resulting in death)	-	u	thenia Gi								years	
	Examiner			- 1		5. 40 4 50.100q	301100 01).								
١,,,		Jer	Sequentially list conditions if any, leading to immediat cause. Enter Underlying		b. — Due to (or as a conseq	uence of):								
	cuted nd ransit	Examiner	that initiated events	1	c								-		
Ď	an ar an ar irial-t		resulting in death) Last		Due to (or as a conseq	uence of):								
8/PD	ficate be executed physician and is the burial-transit	edical			d										
٥	ndifica ng ph		IF FEMALE:									-			
X Q Q	eath certift attending I for use as	Physician/M	23b. Was decedent pregna in the past 12 months	atit	23c. If yes, outo	come of pregna		Ectopic preg	nancv				23d. Date of delive		
_	e death the atten	SICI	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	'		ant at time of de		Other (speci					Month	Day '	Year
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	es ign be	by	Part II. Other significant co		ntributing to de	ath but not resu	alting in the un	derlying caus	e given in	Part I.			use contribute to th		
ecords	w requires been sign should be	ted	Diverticu	lltis							1 🗆	Yes 2	2 ☑ No 3 ☐ Prob	ably 4 □l	Jnknown
င္	as b	Completed									24a. Was		24b. Were auto	psy findings	available
	ysicien: The is certificate hadirector, page	Sol									perfo 1 ☐ Yes	rmed?	death?		
VII a	Physicien: The this certificate ral director, pag	Be	25. Was case referred to mexaminer?							Place of Dea	ath Check only	one)			
0	Physi this c	P	1 ☐ Yes 2 🗓 No			patient 2				☐ Nursing F	lome 5 🏋 Resi	dence	6 ☐ Other (Specify	1)	
	their ne	on:		Pending	28a. Date o (Monti	f Injury 1, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe	how inju	iry occurred		
VISION	r Attending er death. rector: After by the fune	cat	2	nvestigation Could not be				М	1 Tyes	2 🗆 No					
2	or A	Certification:		determined	28e. Place buildin	of Injury - At ho g, etc. <i>(Specif</i> y	me, farm, stre	et, factory, o	fice		28f. Location (City or To	Street ai wn, Stati	nd Number or Rura e)	Route Num	ber,
_	pitel ours erel filled		29a. Certifier 1 🕏 Ce	etifying Phys	eicion: To the	hast of my know	vlodes death								
	To the Hospitel or within 24 hours after to the Funerel Discompletely filled in	edical	(Check only 2 Me	dicel Exemi	ner: On the ba	sis of examinat	ion and/or inve	estigation, in	my opinio	ate and place n, death occu	rred at the time,	date an	and manner as st d place, and due to	ated. the cause(s)
		Me	29b. Signature and title of o	ertifier	1/	1		29c. L	cense nur	mber		29d. Da	ite signed (Month, I	Day, Year)	
,	, AO		Julia -	04/1	Here	2/3/4		D32	800			Nove	mber 3, 2004	4	
5	11		30. Name and address of	erson who co	mpleted cause	death (Item	23a) (Type, P					TOACII	abel Je 200	r	
	ì		Hilary H. Washi					d, Suit	e 205	, Fort W	ashington	, Mar	yland 2074	+	
	* Sta		31. Date filed (Month, Day,	317 0 6		gist ar's Signat	ure	South .	D						
É	Registra	ar _	M	IV 04	7004	Marian	No.	A Comment	7						

State of Maryland / Department of Health and Mental Hygiene 35466 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day SARAH FULTZ OCTOBER /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 506 62nd Avenue # B Seat Pleasant Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F 55 579-62-2563 Yrs. Director Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 28a-f show 10d, Inside City Limits the Medical Exerciter must be notified at Director Yes 2□No Prince Georges MD Seat Pleasant 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 506 62nd Avenue 20743 itетs 23a U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Black þ Specify: 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. am 27 is markad other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Entrepreneur Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isiah Dillard Hattie Pearl Galloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ertment of Health a crtant: If itam 27 ls John C. Fultz II/Son 7502 Greer Dr. Ft. Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 10-22-04 Clinton, Maryland permit.
Depentinimporta
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Marylans 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL Pnysician NEARCTION MINUTE /Medical Due to (or as a consequence of): Examiner BRONARY TEAR Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Completed by Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ABETES MELLITUS 3 Probably KETDACIDIS 1 ☐ Yes 2 ☐ No 4 Unknown HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autops, performed? Yes 21ANo ANEMIA WITH UPPER GI BLEEDING 1 ☐ Yes 2 No 1 ☐ Yes of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 & Flesidence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Division Natural 2 Accident 5 Pending investigation Injury s after death. 1 ☐ Yes 2 ☐ No in by the 1 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21428 Keenms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 7582 Annapolis Road Lanham, Maryland 20784 Linda Green 31. Date filed (Month, Day, Year) OCT 2 6 2004 Registrar

PH	A. FOR	D		State of Ma							ne _{tas} .	
			- Stete Amend Item Registrar				tificate of	Death			12004	35467
	Physicia	an	1. Decedent's Name (First, Middle, La	-	l1en					ate of Death onth	Day Year	3. Time of Death
,	/Medic	al	Joseph /	Ford		Jr.	4b. City, Town, o	ar Longtion of	f Doath	T. 15	2004 4c. County of Dea	5:44 P ^M
	Examin	er	4a. Facility Name (If not institution, gi		יים ידינאי <i>ב</i>	5	CHEVEF		Death			GEORGES
	Funeral		PRINCE GEORGES 5. Social Security Number 6.	Sex 7. Age		(last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8. Da	ate of Birth	9. Bi	nthplace (State or Foreign
	Director		578-66-5275 Usual Residence of Decedent	1⊠M 2□F 53		Yrs.	Months Days	Hours	Jui	ne 18,	1951Fa	rthplace (State or Foreign Jountry) 1 rmont, N.C.
	show	2	10a. State 10b. County P.G.			y, Town or Lo pital	Height					10d. Inside City Limits 12 Yes 2 □ No
	the N 28a-f	ecto	10e. Street and Number			-	10f. Zip Code			10g.	Citizen of What C	Country?
	3a or	Funeral Director	1913 Nova Ave				10.1.2.				.S.A.	, .
	death	nera	11. Marital Status	12. Was Decedent I	ver in U	.S. 13.	Was Decedent of H f Yes, specify Cub	Hispanic Orig	gin? (Specify Y	es or No-	14. Race - Am Black, Wh	
920	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or tiems 23a or 28a-f show event, the Medical Exame actinust te notified at	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	1 Yes 2X N If Yes, Give Year or Dates:	lo		1 ☐ Yes 2 ☐ X No		, r Boko r koun.	, 610.7	Specify: B1	
2 0	72 ho natur	Completed	15. Decedent's 8 (Specify only highest g	ducation rade completed)		16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	pation during most	of working	168	. Kind of Busines	s/Industry
121	within ane. than "	ldu	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use retire k Drive			์ เสล	cobs Pa	permCompani
 	e filed within al Hygiene. I other than ' vent, the Me		12th 17. Father's Name (First, Middle, Las	ot)		1.			r's Name (Firs			.por.oopgm
		To Be	Joseph Ford Sr						a For			
	~ ~ ∞		19a. Informant's Name/Relationship Laura Ford-Mot	<u> </u>		3.	ng Address (Street Nova A				-	Zip Code)
Ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. F	Place of Dispo emetery, crer	sition (Name of natory or other pla	ice)	Date		. Location - City o	
<u>E</u>	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	1	-	ction C		0-28-	04 C	linton,	Md.
Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Lice	Indos	19		Name and Address & S		•	ads S	t,N.E.	
60,	Physician /Medical Examiner e panial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Narcotic Due to (or as b. Due to (or as c. Due to (or as d.	a conseq	uence of):	cion					Onset and Death
.O. Box 68	The law requires that the death certificate ten been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	Ectopic pregnanc	ey .			23d. Date of do Month	elivery Day Year
ds, P	uires that signed b	by	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying cause gr	ven in Part I.	2		. /	to the cause of death? Probably 4 []Unknown
		Completed							2	4a. Was an autopsy performed	prior to death?	
/ita	Physiclan: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hospital:			CH		of Death (Che	ock only one)		
of	Phys this al dii	2	1 X Yes 2 No 27. Manner of Death	1 Inpatie		ER/Outpatier 28b. Time o	IL 3 DUA				6 ☐Other (Sp.	ecify)
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Division	I or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not determine	be 28e. Place of Inj building, et	ury - At h	ome, farm, str	reet, factory, office		28f. Lc	ocation (Stree ity or Town, S	t and Number or F tate) 929 R1	dge Kd.
_	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	edical Ce	29a. Certifier 1 Certifying I	Found in Physician: To the best eminer: On the basis of	of my kno	wledge, deat	h occurred at the to	ime, date and	d place, and du	ue to the caus	n, D.C. e(s) and manner a and place, and du	as stated.
	To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner sta	ated.		29c. Licen				Date signed (Mon	
	M T S		W MAN CI	D. (12.	18.1	John		O.C.M.	Ε			, 2004
10	1		30. Name and address if person wh	o completed cause of d	eath (Iter	n 23a) (Type.						
1	-		MANYSMITS	n. Kore	u;		n Street	. Bali	timore.	Marvl	and 2120	1
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 3 200		ar's Signa		N.					

			For State	State of M	arylan			Health and N	lental Hyg	00 2 eneign	1,	35468
			Registrar 1. Decedent's Name (First, Middle, La	not)		Ce	rtificate of	Death	2. Date of Dea		**	
	Physici	an	1. Decedent's Name (First, Middle, La		Ben				Month Constant	Day \	ear	3. Time of Death OZ 15 5M
	/Medio Examir		4a. Facility Name (If not institution, gir				4b. City, Town,	or Location of Death	Doise	4c. County of		02 0 2
	LXamii	ici_	Suburban Hospita	1			Betheso	la		Montgo	nery	
	Funeral		5. Social Security Number 6.		ge (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Birtl (Month, Day	, Year)	. Birthpla	ace (State or Foreign
	Director		098-42-2331 Usual Residence of Decedent	I M W	40	Yrs.			April	29,1958	New	Ýork
	land ow		10a. State 10b. County		10c. Cit	y, Town or L	ocation				10	Dd. Inside City Limits
	Many Ba-f sh	tor	Marvland Montgom	erv	Ве	ethesd	а					1 X Yes 2 □ No
	ith the or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Count	ry?
	ath w	rail	3 Pooks Hill Rd.	T	-	0		0814		USA		
	ler de Itame	-une	11. Marital Status 1 ∑Never Married 2 ☐ Married	12. Was Decedent Armed Forces	?	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	Mhite, e	
036	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		į	1 ☐ Yes 2 🔀 No	Specify:		Specify:	W	hite
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5	within 72 hours after death with the Maryland ene. ene. ratural, or Itams 23e or 28e-f show had a Wedical Examiner must be notified at	Completed by Funeral	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NDT use retire	Administr		Public :	lea1	th
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Maryland 21215-0036	ld be ental ked o	To Be	Arthur Faber					Rose Viv	ian Kol	odin		
2	shou and M s mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	t and Number or Run	al Route Numbe	r, City or Town, St	ate, Zip (Co <i>d</i> e)
	and 2 ealth n 27 I		Louis Steven Fab	er-Son	1			Hill Rock				
Baltimore	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The most standard that than "natural; or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	1 0	emetery, cre	osition (Name of matory or other pla f Romomba	cance10/24		20c. Location - Ci Clarksbu:	•	
<u> </u>	it. Pa rtmen rtant: njury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Gai			ess of Facility Hin				
T C	Depa Impo		Lowely & (DE								, MD 20904
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	d the deat							Approximate Interval Between
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&	requires that the death certifications is a second to the second by the attending phould be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Feta	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month		y Day Year
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Ann of	e taw n has be ge 2 sh	Completed							24a. Was a autops		e autops	sy findings available pletion of cause of
y Ann Vital Bec	The tacate has page	Con							perform 1 Tes	ned? dea 2 No 1 □	th? Yes 2	P No
كرة چ		Be.	25. Was case referred to medical examiner? 1 Yes 2 DNO	Hospital:	2			26. Place of Death				
0.0	g Phys ar this eral di	n: To	27. Manner of Death	28a. Date of Inju	iry	28b. Time o	IL 3 LI DOA	4 Nursing Ho		ence 6 Other ow injury occurred	Specity)	
TO S	Attending r death. sctor: After	atio	1 Natural 5 Pending 2 Accident investigation		y rear)	Injury		rk?]Yes 2 □No				
beg d	or Atte inter de Directo in by th	Certification:	3 Suicide 6 Could not to determined		jury - At ho	ome, farm, sti	reet, factory, office		28f. Location (St City or Town	reet and Number (n, State)	r Rural i	Route Number,
٥	ospital of hours af uneral D		On Continue D	To the book	-1 1							
J	王 4 正 亩	Medicai	29a. Certifier (Check only one) Certifying P 2 Medicel Exe	nysician: To the best miner: On the basis o and manner st	of examina	tion and/or in	vestigation, in my	me, date and place, opinion, death occurr	ed at the time, d	ause(s) and mann ate and place, and	due to t	he cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of centrier	4 40			29c. Licens	se number	2	9d. Date signed (A	fonth, Da	ay, Year)
	•						1)7	7675	_	10/23/	09	
			30 Name and address of person who	completed cause of	death (Item	1 23a) (Type,	Print)	Borran	ho	2071		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registi	-	ture	1	IN INDX	7	-00		
	Registi		OCT 25 2	004 Jen	war	B	Spark	2/				

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James F. Feddon October 20, 8:57 A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**☑**M 2□F Director 70 235-52-5094 July 28,1934 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f shov Examiner must be notified at Maryland Anne Arundel Directo 1 ☐ Yes 2 No Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1392 Escapade Court 21140 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X2 Yes 2 □ No 1955-61 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 212 No Specify Specity: White 3 Widowed 4X Divorced Completed the Mudical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) Mortgage Banker Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard J. Feddon ဂ Eva Strawderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberleigh M. Murray/Daughter | 3207 Breckenridge Way Riva, Maryland 21140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Lakemont Cemetery 10-23-04 Davidsonville `4 Donation 5 Dother (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service I 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) rob rovera Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) D40519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1667 CroftonCtr Crofton MD ZIII NUSASTER MINZIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2-2 2004 Registrar

1 - State

State of Maryland / Department of Health and Mental Hygier 0 0 L Certificate of Death

35470

9. Birthplace (State or Foreign

10d. Inside City Limits 1X Yes 2 ☐ No

MARYLAND

3. Time of Death

13:25 M

				 Hegistrar 						CCIL	noai	COL	Julin		
		ysicia Viedic		1. Decedent's Name GEO	e (First, Middle, L ORGE HEN	,	FITH	Į.							2. Da
7		amin		4a. Facility Name (I	1			spi	ta		- "		Location	1	nd
		eral ctor		5. Social Security N 216 14 19		Sex 1∏M 2□F	_	(In yrs. la			If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Da (Me MA
	death with the Maryland ms 23e or 28e-f show	politie	lrector	Usual Residence of 10a. State MARYLAND 10e. Street and Nur	10b. County ALLEGA	NY		10c. City,		or Loca	G	o Code			
	ter death wit	Ostroastb	Funeral D	11 WEST 11. Marital Status	MAIN ST	12. Was Dec	orces?	lo		13. Wa	s Dece es, spe	215 dent of H cify Cuba	32 ispanic Ori n, Mexicar	gin? (Sp	ecify Ye
5-0036	72 hours efter natural', or Ite	170	sted by	3 Widowed	_	If Yes, G Year or I Education	ive Dates:	WW	11 16a.	Deceder	nt's Usu	2XI No	Specify: ation		rina

10g. Citizen of What Country? U.S. 14. Race - American Indian. edent of Hispanic Origin? (Specify Yes or No-ecify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.

Year

04

4c. County of Death Allegany

WHITE 16b. Kind of Business/Industry

(Give kind of work done during most of working life. DO NOT use retired) BRICKLAYER

CONSTRUCTION

11 17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12)

WILLIAM F. GRIFFITH

PEARL McKENZIE

19a, Informant's Name/Relationship (Type, Print)

HARRIET GRIFFITH / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

18. Mother's Name (First, Middle, Maiden Sumame)

2. Date of Death

03

Month

8. Date of Birth (Month, Day, MAY 8

11 W. MAIN ST., FROSTBURG, MD 21532

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service License

THE CUMBERLAND CREMATORY 11/4/04

CUMBERLAND, MD

22. Name and Address of Facility

60 W. MAIN STREET FROSTBURC, MD 21532

20c. Location - City or Town, State

SOWERS FUNERAL HOME, P.A.

College (1-4or 5+)

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

disease or condition resulting in death)

20a. Method of Disposition

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9□ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

3 Probably 4 □Unknown

autopsy performe 1 🗌 Yes 2[26. Place of Death (Check only one)

Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Impatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

3□ DOA 2 ER/Outpatient 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

D0033280

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and tille o

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 - Homicide

29c. License number

29d. Date signed (Month, Day, Year) Nov 2004

21502

30. Name and addres of pers in who completed cause of death (Item 23a) (Type, Print) Avenue, Comberland, MD

DR. SUNIC GUPTON 625 KENT 31. Date filed (Month, Day, Year)

NOV 0 9 2004

6 Could not be determined

certifie

\$32. Registrar's Signature

State Registrar

Pages 1 and 2 should be filad within nent of Health and Mental Hygiene. Int: If item 27 is marked othar then " Iry or other traumatic event, Ite Ma.

parmit. Page Department of Importent: If any injury or once. injury or

Physician

/Medical

Examiner

attending physicien and for use as the burial-transit

the

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been signad be should be deta

s certificate has b lirector, page 2 s

After this

neral Director: A

within 24 hours e To the Funeral L

Hospital or Attending

death.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

by

Completed

Be

P

Certification:

cai

Be

Baltimore, Maryland 2121

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of I rtificate of	lealth and I Death		gierze () [4	35471
	Physic /Medi		1. Decedent's Name (First, Middle, Last Edward Ki	•	Jr,			2. Date of Des Month	Day	Year	3. Time of Death
	Exami	ner	4a. Fecility Name (If not institution, given MANCKIN MANCKIN MANCKIN S. Social Security Number 6, S		and higher	4b. City, Town, o	ANNE If Under 24 Hrs.	1	4c. County	ners	
	Funeral Director			M 2□F 75	Yrs.	Months Days	Hours Min.	8. Date of Birt 1 0 / 3 0 /	1928	9. Birthp Cour De I a	place (State or Foreign htry) AWare
	Maryland	tor	10a. State 10b. County Maryland Som		inces	ss Anne				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 11974 Edgehil	l Terrace		10f. Zip Code 218	53		10g. Citizen of 1	What Cour	ntry?
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Madical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		_1	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- pecify Rican, etc.)	14. Rad Blad	e - Americ ck, White, v: Whi	etc.
21215-0036	be filed within 72 hours htal Hygiene. ed other than "natural", event, the Medical Exa	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	college (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retire Denter/1	during most of work d)	1	16b. Kind of Bi		ovement
and	I be filed ntal Hyg ed other: event,	Be	17. Father's Name (First, Middle, Last) Edward King G	ordy Sr	<u> </u>	ocircer / i	18. Mother's Nam	e (First, Middle,	Maiden Suman	тө)	vellenc
Maryl	d 2 should the and Menity is and Menity is a market traumatic of	2	19a. Informant's Name/Relationship (7) Wanda L. Gordy	ype, Print)			and Number or Rur Fruitla		r, City or Town,	State, Zip	Code)
Baltimore, Maryland	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. In cortent: If item 27 is marked other than any injury or other traumatic event, I a Medical		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	20b. Pla Removal from State Wic	ace of Dispos metery, crem OMICC	sition (Name of nation of Other place) Memor	F8) 1		20c. Location -	City or To	
Baltir	permit. F Departme Imcorter any injur		21. Signature of Fune all Service Licens	- 1 u	22 H	0118Way		1 Home	Profe	ssio	nal Assor
68760,	Physician and Street per executed by sician and physician and street the private that is the private that the private that the private that the private that the private that the private that the private that the private that t	edicai Examiner	23a. Part1. Enter the disease, or composition, or heart failure. List only to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	hications that caused the death. one cause on each line. a	ASCVI) ence of):	or the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
P.O. Box 6	ne death certif the attending thed for use a	by Physician/Me	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan- 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	y Day Year
rds, P	w requires that the bod by should be detac		Part II. Other significant conditions co	ntributing to death but not result	ting in the und	derlying cause give	en in Part I.				e cause of death?
al Reco	The law ate has b page 2 st	Completed		9 w				24a. Was ar autops perform 1 Yes 2	y pined? di	/ere autop: rior to com eath? Yes 2	sy findings available pletion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	-lospital: 1 Inpatient 2 El 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify)	8b. Time of Injury	Work M 1 🗀	/es 2 □No		nce 6 Othe	nd	
٥	Hospitel (24 hours al Funerel Ditely filled in	Medical Cer	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowl ner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the timestigation, in my op	e, date and place, a inion, death occurre	and due to the co-		ner as sta	ted. he cause(s)
	To the within To the Comple		29b. Signature and title of certifier Will Will William W	and married states.		29c. License		29	od. Date signed	(Month, D	
			Ve. (Name and address of person who do		DIVISI	ION St.	5421	SZURY	MD 218	804	
	Sta Registra		OCT 2 5 2	004 Serveral	2	Sport	2				

		410	1 - For State Registrar		artment of Health and rtificate of Death	Reg. I		35472
	Physic /Medi		1. Decedent's Name (First, Middle, Last FRANK Graham,				Day Year 3 2004	3. Time of Death 2:15 A ^M
	Examir		4a. Facility Name (If not institution, give Anne Arundel Me	street and number)	4b. City, Town, or Location of Deat Annapolis	1	4c. County of Death Anne Aruno	lle
	Funeral Director		5. Social Security Number 6. Se 218-34-9484 Usual Residence of Decedent	7. Age (In yrs. last birthday) MM 2□F 65 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Nov. 20, 19	9. Birthpl Count 38 Virgi	ace (State or Foreign ry) inia
	th the Maryland or 28a-f show a notified at	irector	10a. State 10b. County Maryland Queen Ar. 10e. Street and Number	10c. City, Town or Lo	nester 101. Zip Code	10g. C	10 Ditizen of What Count	od. Inside City Limits 1) Yes 2 □ No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show styl injury or other traumatic event, the Medical Examinator institutional be notified at ance.	by Funeral Director	407 Ellicott Dri 11 Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	21619 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ★ No Specify:		SA 14. Race - America Black, White, e Specify: B1a	tc.
0-5121	within 72 ho ene. then *natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	(Give Completed) (Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	Kind of Business/Ind	
Maryland 21215-0036	should be filed withind Mental Hygiene. I marked other ther Imatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Frank Graham, Sr	•	Nettie	ne (First, Middle, Maide Harvey		4791-1-1-1
	1 and 2 shot Health and tem 27 is mother traum		19a. Informant's Name/Relationship (T) Clarence Graha	m /Brother P.O	ng Address <i>(Street and Number or Ru</i> •Box 365, Queenst			Code)
altimore,	Pages 1 nent of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	idinoval iloni otato	sition (Name of matory or other place) Ley Cem. 10-0		Location - City or Tow ester, Mary	
Bait	permit. Page Department of Important: If any injury or once.		21. Signature of Funerat Service Licens	22	Name and Address of Facility Bennie Smith Fun 426 Dover Street	eral Home		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compi shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		er the mode of dying, such as cardiac	or respiratory arrest,		Approximate interval Between Onset and Death
Ď,	certificate be executed rding physicien and use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
09/89	rtificate b ng physici as the bu	Medicai	IF FEMALE:	d	1000			
O. BOX	at the death certific by the attending p tached for use as I	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month D	y day Year
ecords, P	The law requires that the death te has been signed by the atter age 2 should be detached for u	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
ב		Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ □	prior to comp death?	y findings available pletion of cause of
	ng Phy Iter this Ineral d	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Inpatient 2 FR/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Other	h (Check only one) me 5 Residence 28d. Describe how inju		
Ž		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Street as City or Town, State	θ)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledicai	one)	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as state d place, and due to th	ed. ne cause(s)
	To To con	Σ.	29b. Signature and Atle of certifier	CM	29c. License number (1) 32 (13 (6)	29d. Da	te signed (Month, Da	y, Year)
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, I	13036 Print Orive Cl	erte mo.	21619	
	Sta Registra	-	31. Date filed (Month, Day, Year)	32. Registrar's Signature	backer			

cia lic		1. Decedent's Name (First, Middle	, Last)	-			.,,,,	e of L	<u> </u>		2. Date of De			14	3. Time of Death
		Mary Elizabeth Gu	ıy								Month October	Da 29		Year 104	3:00 P.M
ine		4a. Facility Name (If not institution		et and nu	mber)		4b. City,	Town, or	Location of	of Death		40	. County	of Death	
		St. Mary's Nursin	g Cen	ter				ardto					St. M	lary's	
1		5. Social Security Number	6. Sex 1 ☐ M	2 XX F	7. Age (In yrs.	last birthday) Yrs.	Months Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year		9. Birthp	place (State or Foreign
r		21.7-42-4890 Usual Residence of Decedent			83	113.					March 3	1, 15	921	Mary	land
		10a. State 10b. County			10c. C	ty, Town or Lo	ocation							1	0d. Inside City Limits
	to	Maryland St. Ma	ry's		Lov	eville									1 ☐ Yes 2 🙀 No
	Director	10e. Street and Number			•		10f. Zig	Code				10g. Ci	itizen of V	Vhat Cour	ntry?
		27707 Pt. Lookout R	load					0656				USA			
	Funerai	11. Marital Status		Armed F		J.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	o-		e - Americ k, White,	can Indian, etc.
	by Fi	1 Never Married 2 Marr 3 ☑ Widowed 4 Divorced	ied	1 ☐ Yes If Yes, G Year or E	ive -		1 🗌 Yeş	2 No	Specify:				Specify	. Whi	te
		15. Deceden	t's Educat		Jaies.	16a. Dece	dent's Usu	al Occupa	ation			16b. F	Kind of Bu	ısiness/în	dustry
	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade c	ompleted)		(Give	kind of wo DO NDT u	rk done d	luring mos	t of worki	ing				,
	EO	1.2		College (1-4or 5+)	Homema	ker					Ow	n Hom	е	
	Be C	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	e (First, Middle	, Maidei	n Sumam	ю)	
	2	George Henry Payne							Ca	theri	ne Marga	ret B	Bond		
Ì		19a. Informant's Name/Relations	hip <i>(Typ</i> e,	Print)		19b. Maili	ng Address	s (Street a	and Numbe	er or Rura	al Route Numb	er, City	or Town,	State, Zip	Code)
		Mary Sonia Walker/D	aughte	er	205						ville, M			City or T	own, State
		20a. Method of Disposition 1 St Burial 2 Cremation	3 🗌 Rem	noval from	State	Place of Dispo cemetery, crea								•	
		`4 ☐Donation 5 ☐ Other (S			St	. Joseph					3,2004		ganza,		
Suca		21. Signature of Funeral Service	OPYN	Å	e En dine	· / ·			ardine: Maryl		eral Home 20650	e, P.	A., P	. 0. 1	3ox 270
		23a. Part1. Enter the disease, dr shock, or heart failure. List	complica	tions that	caused the dea						or respiratory a	ırrest,			Approximate Interval Between
1		Immediate Cause (Final	Offiny Office	cause on	Sontra	1 (~	inle	P	1.08	· · ·	rhaa	0,			Onset and Death
1		disease or condition resulting in death)	a	Due to	(or as a conse	quence of):	777	/	ven	(0)	shag				
r		Sequentially list conditions,	b								•				
	Examiner	if any, leading to immediate cause. Enter Underlying		Due to	(or as a conse										
	am				(quence of):									
- 1	~	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to											
		Cause (Disease or injury that initiated events resulting in death) Last) c	Due to	(or as a conse										
	cai	that initiated events	d	Due to											
	edicai	that initiated events resulting in death) Last	d	. If yes, ou	(or as a conse	quence of):							23d. Dat	e of delive	ery
	edicai	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	. If yes, ou 1∐Live 4∐Preg	(or as a conse	quence of): nancy al death 3[□Ectopic p						23d. Dat		ery Day Year
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Physici /Medi		Decedent's Name (First, Middle, Last Patricia		ehris			2. Date of Deat Month October	Day Year 31, 2004	3. Time of Death 11:30 a.m
Examir		4a. Fecility Name (If not institution, give St. Mary s Ho 5. Social Security Number 6. Se	ospital x 7. Age (In yrs	s. last birthday)	4b. City, Town, or Leon. If Under 1 Year Months Days	ardtown	8. Date of Birth	4c. County of Dea St. Mai	
Director	(I	187–22–5541 Usual Residence of Decedent 10a. State 10b. County		4 Yrs.		Hours Min.	Mar. 19,	1930 Per	nnsylvania
death with the Maryland ms 23a or 28a-f show Froust be rediffed at	Director	Maryland St. Ma				anicsvil		0g. Citizen of What Co	1 ☐ Yes 2 € No
s 1 and 2 should be lited within 72 hours after death with the Marylan of Health and Mental Hygiene it has a second second to the then a second second the content of the second	by Funeral D	41318 Shannon Way 11. Maritaf Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ■Yes 2 □ No 19 If Yes, Give Year or Dates: 19	50-	2065 Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	United S 14. Race - Ame Black, Whit Specify: Whit	erican Indian, le, etc.
d within 72 hours after gjene. sr then "natural", or Ita	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation	16a. Dece	dent's Usuaf Occupa kind of work done of DO NOT use retired Homema	during most of wo !)		16b. Kind of Business Own Hot	
ould be fitted value between the state event, it	To Be C	17. Father's Name (First, Middle, Last) Thomas W. McGui	re				me <i>(First, Middl</i> e, M a_Marie C	- 11-0	
and 2 should lealth and Men m 27 is marke		19a. Informant's Name/Relationship (T) Rama D. Gehris/Da						City or Town, State,	
permit. Pages 1 ar Department of Hea Important: If item any injury or otha once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State Ar	Pface of Dispo cemetery, cres lingtos	osition (Name of matory or other place n Nationa	e) 1 11-1	Date 2 6-2004 A	20c. Location - City or ${ m arlington}$,	Town, State Virginia
permii Depar Impo		21. Signature of Funeral Service Licens Edward N. Brinsfi 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	eld. Jr. MC	0052 2	2955 Holl	ywood Ro	ad, Leona	Funeral Hoardtown, MI	Approximate Interval Between
Physician Physician and Physician who was a physician and Physician and	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aActe	equence of):	Respirat	07	Failon Failon		Onset and Death
the death certil y the attending iched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2271/0 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
w requires that been signed b	by	Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	nderlying cause give	en in Part I.		accoluse contribute to	o the cause of death?
	Completed	A-tsial	Fibrillati	0 4			24a Was ar autops perform 1 \(\text{Yes} \) 2	y prior to death?	utopsy findings available completion of cause of
nysician nis certification	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1: Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	or	ath (Check only one Home 5 ☐ Reside	e) ince 6 ⊡Other <i>(Spe</i>	ocify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funaraf Director: After this certifica completely filled in by the funeral director,	Certification:	27. Manner of Death		28b. Time of fnjury home, farm, st	M 1	y at k? Yes 2 □ No		w injury occurred reet and Number or R , State)	ural Route Number,
Hospital of 24 hours a Funaral C	Medical Ce		ysician: To the best of my ki iiner: On the basis of exami and manner stated.						
To the within To the compl	Me	29b. Signature and title of certifier D. Shelv	MD		29c. Licens		1	9d. Date signed (Mont	*
		30. Name and address of person who of the second se	completed cause of death (It	em 23a) (Type,	Print) ROAD	, Po	ina.	foederica	2067 MB
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature					

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ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2004 35475 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:50P Helen Mary Alice Greenwell 22, 2004 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince George Southern Maryland Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 21, 15 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 64 215-38-3364 1940 Director Washington, DC. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "naturel", or items 23e or 28a-f show other treumatic event, the Modical Examiner must be notified at Prince George Camp Springs Maryland 1X Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 6336 Maxwell Drive; Apt. 2 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natureli, or item eny injury or other treumatic event, the Modral Examiner once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Jones Mary Alice Harper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Greenwell, Sr./Spouse 6336 Maxwell Dr. Apt. 2, Camp Springs, MD. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park Oct. 30, 2004 Landover, MD. A □ Donation 5 □ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LYMPHOID Physician LEUKEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 **X** No this certificate 1 Yes the Hospital or Attending Physicien: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei cai completely (Check only onel and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D48158 OCT 23, 2004 1 disouragia wish 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SISOM OSIA, 6192 OXON HILL ROAD STE SOO OXON HILL MD 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 2 6 2004 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiezen 0 [4 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Evleen I. Green October 13, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Fort Washington Prince George's Millenium Nursing And Rehabilitation Center 8. Date of Birth Alpust 20, 941918 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1□M 2√2F 220-32-6866 86 Yrs. Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hyglene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or iteme 23a or 28e-f show traumatic event, it.e Medical Examinational Le notified at 1 Tes 2 No Director Brandwine Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14307 Neal Drive 20613 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black ð 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Food Server Board of Education (Retired) and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Brooks Janie Moore 19a. Informant's Name/Relationship (Type, Print)
Mr. Andrew L. Chase (Nephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9700 Linwood Avenue Seabrook, Mary Land 20706 permit. Pages 1 and 2: Depertment of Health at Important: if item 27 is any Injury or other trace 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Catholic Church Cemetery

Completery

Cottober 18,2004 Clinton, Maryland 20a. Method of Disposition 1XXBurial 2 Cremation 3 □ Removal from State 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Connective Heart Failure 1 week /Medical Due to (or as a consequence of):
Coronary Artery Disease 5 years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner 10 years Diabetes Mellitus The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medicai as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 25 No 2 No 1 🗌 Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2XXVo 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24535 October 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi N. Berwa, M.D. 7700 Old Branch Avenue Suite C-101 Clinton, Maryland 20735 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 2 6 2004 Registrar DHMH 17 Rev 1/2001

			For State Registrar		State of M	aryland /		artment of rtificate of			lental Hy	gien	UUL	ŧ	35477
		(4)	1. Decedent's Name	e (First, Middle, La	st)						2. Date of De	eath			3. Time of Death
de .	Physicia /Medic		SAMI	UEL LEE	GRAV	ELY, JR					Month OCT	Da O		_{Year} 2004	6 - E 1 A
	Examin		4a. Facility Name (/	f not institution, give	e street and number)			4b. City, Town,	or Locatio	on of Death		40	. County o		0:31A
			NATIONA	AL NAVAL	MEDICAL CI	ENTER		BE'	THESD				MON'	TGOM	ERY
	, Funeral		5. Social Security N	1	ex 7. Ag 1. M. 2 ☐ F	e (In yrs. last l		If Under 1 Yea Months Days		ler 24 Hrs. s Min.	8. Date of Bi	av. Year)	9. Birthp Cour	lace (State or Foreign
	Director		228-09-39	758	ALIW: ZUF	82	Yrs.				June 4	, 19	922		Va.
	and		Usual Residence of 10a. State	10b. County	-	10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
	Manyl f sho	or	Va.	Prince W	illiam	Haym	arke	t							1 ☐ Yes 2 ☑ No
	28a	rect	10e. Street and Nur		11114111	1149111		10f. Zip Code				10g. C	tizen of Wh	nat Cour	ntry?
	a with	i Di	15956 Wat	terfall R	oad			20169				11.	S.A		
	death	Funeral Director	11. Marital Status	CTTAIL K	12. Was Decedent	Ever in U.S.	13.	Was Decedent of	Hispanic	Origin? (Spe	cify Yes or No		14. Race		
9	or Ite		1 Never Marri	ied 2 XMarried	Armed Forces?	No .		fYes, specify Cu 1 □ Yes 2 273 No			nican, etc.)	1	Specify:	White,	_
21215-0036	ba iliod within 72 hours after death with the Maryland ital Hygiena. Id other than "natural", or Items 23a or 28a-f show event, Ite Modical Evacities must be coulded.	d by	3 Widowed	4 Divorced	If Yes, Give Z Year or Dates:	19/48		ILI 165 ZA.NV	э эрөс				Specify:1	этас	
5	72 h	Completed	(Spec	15. Decedent's Ed		16	a. Deced (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e during m	ost of worki	ng	16b. F	(ind of Bus	iness/In	dustry
121	within ena. than "	mpi	Elementary/Seco	ondary (0-12)	College (1-4or							11	C M		
2	a filed within al Hygiena. I other than 'vent, II.e Me		17. Father's Name	(First Middle Last)	4	U	. 5 .	Naval Of			(First, Middle	_	S. Na		
anc	d ba f ntal h ed of	Be	Samuel L.								ge Sim		, oumano,	′	
Ξ	should ba nd Mental marked o	2		ame/Relationship (15	9b. Mailir	ng Address (Stree					or Town. S	tate. Zio	Code)
Maryland	nd 2 still art lith art 27 is ritrau		Alma B. (, ,		10		Waterfa							·
re,	s 1 ar f Hea item gthe		20a. Method of Disp	position		20b. Place	of Dispo	sition (Name of		_	ate		ocation - C		wn, State
Baltimore,	parmit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny Injury or other traumatic evones.			☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State	Arli	ngto emet	natory)or other pl n Nation erv	ial	12/17	7/ 04	Ar1	lingto	on,V	a.
ati	mit. partm porte / Inju		21. Signature of Fu	ineral Service Licer	nsee	, ,		. Name and Add	ress of Fac	cility Ame	s Fune				
Ô	P m m m		Born	raul o	Hmer	-	89	14 Quarı	y Rd	.Manas	sas,Va	. 20)110		
	4		23a, Part1. Enter the shock, or hea	he disease, or com int failure. List only	plications that caused one cause on each li	the death. Do	o not ent	er the mode of dy	ring, such	as cardiac o	r respiratory a	ırrest,			Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final	SEPT	IC SHOO	CK								Onset and Death
	/Medical		resulting in death)		Due to (or as	a consequenc	e of):								
	Examiner	L	Sequentially list co	nditions,	b										
	ed sit	ine	cause. Enter Unde Cause (Disease or	nmediate .	Due to (or as	a consequenc	e of):								
	and I-tran	Examiner	that initiated events resulting in death)	S	c. Due to (or as	a consequenc	e of):							-	
38760,	icate be executed physician and s the burial-transit	aiE		l	,		,								
587		edicai			_ d										
Вох	attending p for usa as	N/M	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome			-					23d. Date	of delive	ery
ă	atte	Physician/M	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a]Ectopic pregnan] Other <i>(specity)</i> ,	су				Monti	h	Day Year
0	t the de by the a tached	hys	9 ☐ Unknown		9□ Unknown										
S,	law requires that the as baen signed by th 2 should be detache	by P	Part II. Other signif	ficant conditions o	ontributing to death b	ut not resulting	in the u	nderlying cause g	iven in Pa	rt I.	23e. Did t	obacco	use contrib	ute to th	e cause of death?
ıd	w require baen sig should b										1 🗆	Yes 2	XDNo 3	☐ Prob	ably 4 □Unknown
ecords,	elawr hasba je 2 sh	Completed									24a. Was		24b. We	ere autopor to cor	psy findings available inpletion of cause of
$\mathbf{\alpha}$	Th ata pag	Corr										rmed? 2 ⊊ No		ath?]Yes	2 No
Vital	Physicien: 1 this certifical ral director, p	Be (25. Was case refer examiner?	red to medical	11					ce of Death	(Check only o	one)			
of\	Physic this cral dire	T _o	1 ☐ Yes 2 💢		Hospital: 1 Inpatie			t 3 DOA			ne 5□Resi				/)
on c	ng fter Ine	ion:	27. Manner of Deat 1 X Natural	5 Pending	28a. Date of Inju (Month, Da	y Year)	. Time of Injury	28c. Inj W	uryat ork? ⊒Yes 2	1	8d. Describe	now inju	ry occurred	1	
isic	r Attending er death. rector; Afte by the fune	icat	2 Accident 3 Suicide	investigation 6 ☐ Could not be	e 29a Place of Ini	urv - At home.	farm str				t8f. Location (Street ar	nd Number	or Rura	I Route Number,
Division	l or A after Dire	Certification:	4 🗌 Homicide	determined		c. (Specify)		oot, taotory, othor	,		City or To				
	spita nours neral		29a. Certifier		ysicien: To the best										
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	(Check only one)	2 Medical Exer	niner: On the basis o and manner st		and/or in	estigation, in my	opinion, d	eath occurre	ed at the time,	date an	d place, an	d due to	the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ž	29b. Signature and	title of certifier	1 05	BORN	1		se numbe		1	_	te signed (
)	GI.		In	11 0				MI		6 (DC)			20	-	
	10		30. Name and addr		completed cause of o			Print)			IAL NAV				ENTER
			31. Date filed (Mon	ERIK O		J MC US ar's Signature	A	,		RETHES	DA MD	2 0 88	39-560	00	
k:	Sta Registr		_		004 Sen	ar s Signature	19	Spark	2						
84			U	01 20 -				. /							

				State of Ma	arylani	-	tificate of		ivientai my	Reg. No.)4:	35478
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medio		Darrin Hagist (ridiey					Octobe	er 20, 2	004	6:35 PM
	Examin	er	4a. Facility Name (If not institution, gir	ve street and number)				4b. City, Town, or	Location of Deat	h 4c. County	of Death	
			Friends Nursing					Sandy			gomery	/
	Funeral Director			Sex 7. Ag 1X M 2□ F	e (In yrs. la 87	ast birthday) Yrs.	If Under 1 Yea Months Days			th ay, Year) 1, 1917	9. Birthpla Countr I1111	ace (State or Foreign ry) nois
	inyland show		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				100	d. Inside City Limits
	Sa-f s	Director	Maryland Montgon	nery	San	dy Spr	ing					1∭ Yes 2 □ No
	ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Countr	ry?
	ath v	rai	17401 Quaker Ln.	T			20860				SA	
0000	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 Yes, Give Year or Dates:			Vas Decedent of i Yes, specify Cul ☐ Yes 2∏ No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specif	ck, White, et y: Wh	
0-0171	vithin 72 ho ne. hen "netur e Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	i+)	(Give life. L		pation during most of wor ed)	king	16b. Kind of B		ustry
V	lled v flygie her ti nt, m	ပိ	17. Father's Name (First, Middle, Last	4 Yrs.		Engin	eer	10 Methodo Nos	no (First Middle	NASA		
2	tal F	Be						18. Mother's Nan			ne)	
Ž	d Mer d Mer narke	욘	George M. Gridle			40h Mailia	- Add (Ot	Luell tand Number or Ru	a Darri		Ou 1. The C	S. (6.1
<u>Z</u>	d 2 sl th and 7 is n traur		George M. Gridle					er Ct. Cro				iode)
ני ע	Health		20a. Method of Disposition	.y bon	20b. Pla		sition (Name of natory or other pla		Date	20c. Location		m. State
Daltillion	ages ant of ft: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				oatory or other pla Cemetery		10/25/04			
	artme ortan injur		21. Signature of Funeral Service Lice		DOIL			ess of Facility H		Silver		
ă	Per Per Per Per Per Per Per Per Per Per		Jench El	Ul		11	800 New	Hampshire	e Ave. S	Silver S		, MD 20904
	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. ie.	Do not ente	er the mode of dy	ing, such as cardiad	or respiratory a	rrest,	; II	Approximate nterval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. PARKI		DN 1S		ASE			Ð	Onset and Death GHT YEARS
	D #	ner			-10 10 (0.	20 2 001.004	301.00 01,1				1	
	and trens	edicai Examiner	Sequentially list conditions,	b	Due to (or	as a conseq	uence of):					
Š	be ex ician burial	a E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C								
ò	physic the	ope	resulting in death) Last		Due to (or a	as a consequ	uence of):				į	
<	certif rding se es		L	d							1	
ź	etter for a	ciar	David Other Indiana and dist				(- David	1 001 014	Maria Ser 10		F(1) = 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
į	the c yy the echec	Physician/N	Part II. Other algnificant conditions of	contributing to death bu	it not resur	ting in the un	deriying cause g	ven in Part I.		Yea 2 No	ntribute to t 3 □ Proba	he cauae of death? blv 4 □ Unknown
,	s thet	by P								160 21010	0_11000	bry 4 directions
3	To the Hospital or Attending Physicien: The law requires thet the death certificete be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-trensit	Completed I								an autopsy rmed?	avail	autopsy findings able prior to pletion of cause ath?
	The ste he page	S							10	Yes No	10	Yes 2□No
2	sien: artific actor,	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	one)		
	hysic his or	၉	1 □ Yes No	Hospital: 1 ☐ Inpatie		R/Outpatient	3LI DOA			dence 6 □Oth	_	
	ending P sath. or: After t the funera	ation:	27. Manner of Death Naturel 5 Pending 2 Accident investigatio		Year)	28b. Time of Injury	M 1	ryat irk?]Yes 2∐No	28d. Describe	how injury occur	red	
	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc	iry - At hon . <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (a City or Tou	Street and Numb vn, State)	er or Rural f	Route Number,
	ne Hospi n 24 hou ne Funer pletely fill	edicai	29a. Certifier (Check only one) Certifying Property 2 Medical Example 1	yeician: To the best of niner: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred at the ti estigation, in my	me, date end place, opinion, death occur	, and due to the rred at the time,	ceuse(s) and ma date and place,	inner as stat and due to th	ed. he cause(s)
	To ti To ti COM	Σ	29b. Signature and title of certifier				29c. Licen	se number		29d. Date signe	d (Month, Da	ay, Year)
	20		Janni M.	Hanna	nM	0	D2.	3124	0	CHOPER	.72.	2004
			30. Name and address of person who DENNIS HANNIN	completed cause of de	eath (Item 2	23a) (Type, F	Print) NOY SPR	V6 RDAD'	DINE	y, Man	LYCAN	D 20832
	Sta Registra		31. Date filed (Month, Day, Year) OCT 2 5 20	32. Registra	r's Signatu	ire &	Spark			, , , , ,		

				For State Registrar		State of	f Marylan	-	rtment of F tificate of		Mental H	ygien Reg. N	/ 11 11	35479
				1. Decedent's Name (Fir	st, Middle, La	st)					2. Date of I	Death		3. Time of Death
		Physici /Medi		Kaymor	JE	Sund	Ge	EHLE			Octobe		11	03:22 AM
		Examir		4a. Facility Name (If not	_		nber)		•	r Location of Dea		4	c. County of Death	
w				CARROLL			ITER			MINSTE			CARROLI	
5		Funeral		5. Social Security Number		ex ☑M 2☐F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, L	Day, Yea.	r) Cou	place (State or Foreign intry)
1		Director		212-32-01 Usual Residence of Dec	13	21	70	113.			11/14	/19:	33 MAR	YLAND
W		show			. County		10c. City	, Town or Loc	ation					10d. Inside City Limits
5		B-f st	ioi	MD. C	ARROL	L	F	'INKSB	URG					1 □ Yes 2 💆 No
		ith the Mi or 28a-f)ire	10e. Street and Number					10f. Zip Code			10g. C	itizen of What Cou	intry?
9		ath w	Funeral Director	2071 BALT	IMORE				210				USA	
7		after dea or Itams	une	11. Marital Status	AT Marinina	Armed For		S. 13. W	as Decedent of F Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or Note Rican, etc.)	10-	14. Race - Ameri Black, White	
3	36	rs aft	by F	1 Never Married 3 Widowed 4		1 ☐ Yes If Yes, Give Year or Da	е	1	□ Yes 2 No	Specify:			Specify: WH	ITE
EDWAR!	21215-0036	within 72 hours after death with the Maryland sne. than "natural", or Itams 23a or 28a-f show he Madical Exeminat he notified at	ed	15.	Decedent's E	ducation		16a. Deced	ent's Usual Occup	ation		16b.	Kind of Business/tr	
12	215	hin 7:	ple	(Specify or Elementary/Secondary		de completed) College (1-	-4or 5+)	`life. D	rind of work done O NOT use retired	4)	orking			
	7	filed wit Hygiene other tha	Completed	8	(ТО	OL REPA	AIRMAN		MAI	NUFACTUI	RING
9	nd	be filed within 72 hours after death with the Maryla hal Hygiene. dd other than "natural", or Itame 23e or 28e-f ehon event, the Medical Exeminer man be notilled at	Be	17. Father's Name (First,			ILLIAM	CEMM	TE		ime <i>(First, Middi</i> E MAY			
5	<u>Y</u>	2 should be filed withir and Mental Hygiene. is marked other than aumatic evant, the M.	2				TPTTAM							
Non	Maryland	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		JENNIFER			-WIFE		,				or Town, State, Zij URG , MD	
5	5	of Health of Health litem 27 i		20a. Method of Disposition			20b. P	lace of Dispos	ition (Name of	T	Date		ocation - City or T	
4	Baltimore,	permit. Pages Department of I Important: If its any Injury or o		1 Burial 2 Cre					atory`or other plac MEM . GZ		10/25/	04]	FINKSBU	RG, MD.
V	Ħ	mit. F partm sortar Injur		. (Service Licer								NERAL HO	
	ä	Per Per Per Per Per Per Per Per Per Per											TER, MD	
				23a. Part1. Enter the dis shock, or heart fail	sease, or com ure. List only	plications that ca	used the death	. Do not ente	r the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
		Pnysician		Immediate Cause (Final disease or condition		. Me	tarici	ic nor	-Swell	cell Lu	N CAN	en		Onset and Death
		/Medical Examiner		resulting in death)			or as a consequ				7			
		Laminer	<u></u>	Sequentially list condition	ns,	b. Due to (c	or as a consequ	ience of):						
		ted	nine	if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	1) OI 60G	or as a correcto	ience orj.						
	ς,	execu n and ial-tra	Examiner	resulting in death) Last	- 1	Due to (c	or as a consequ	ience of):						
	8760,	icate be executed physician and s the burial-transit	edicai		(d								
	9		Medi	IE EENAL E.		77								
	Š	attending for use as	an/N	IF FEMALE: 23b. Was decedent preg in the past 12 mont		23c. If yes, outc	come of pregnar		Ectopic pregnancy				23d. Date of deliv	•
	O. E.	at the dea by the at tached fo	Physician/M	1 Yes 2 No	115?	4□Pregna 9□ Unkno	ant at time of de wn	eath 5□	Other (specify)				MONTE	Day Year
	Ρ.	that the sed by detacl		Part II. Other significant	conditions	ontributing to dea	ath but not resu	Iting in the un	derlving cause giv	en in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?
	ds,	uires thal signed t Id be det	d by			,			, 3		1 🗆	Yes 2	No 3 Prot	oably 4 Unknown
	50	w requ	Completed								24a, Wa	s an	24b. Were auto	posy findings available
	Re	The lav	dmc								perl	opsy ormed?		ppsy findings available mpletion of cause of
	ta	iclan: Th certificate rector, pag	a	25. Was case referred to	medical					26. Place of De	1 ☐ Yes ath (Check only		1 Yes	2010
	Į	Phyaicl this cer al direc	To B	examiner?		Hospital:	patient 2 E	ER/Outpatient	3□ DOA Oth	00			6 ☐Other (Specif	(y)
	n o	Attanding Physiclan: The law requires that the death certif refath. r death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a		27. Manper of Death 1 2 Natural 5	Pending	28a. Date of (Month	f Injury n, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe	how inju	iry occurred	
	Sio	ttandi death. ctor: A / the fu	catl	2 Accident	investigation					Yes 2 □ No				
	Division of Vital Records, P.O. Box	or At after d Direct in by	Certification:	4 Homicide	determined	286. Place	of Injury - At hor g, etc. (Specify	me, farm, stre)	et, factory, office		28f. Location City or To		nd Number or Rura e)	al Route Number,
		Hospital or 4 hours afte Funaral Dira tely filled in b	J Ce	29a. Certifier 1	Certifying Ph	vsician: To the l	hest of my knov	vledge death	occurred at the tin	ae date and plac	e and due to the	Causals	and manner as s	tated
		To the Hospital or Attant within 24 hours after deatl To the Funaral Director: completely filled in by the	edical	(Check only 2 one)	Medical Exar	niner: On the ba	sis of examinati	ion and/or inve	estigation, in my of	pinion, death occ	urred at the time	, date an	d place, and due to	the cause(s)
		To the within 2 To the complet	Me	29b. Signature and title of	of certifier	1. 0			29c. Licenso	number		29d. Da	ate signed (Month,	Day, Year)
)	Λ) SC		MD			DAT	77174		OCH	5 55 make	2004
		Mar		30. Name and address of	veon woo	completed cause	of death (Item	23a) (Type, P	rint) 200	MEMORI	AL AVE		- 25	
		. 6		31 Date filed (Atomb De	Y Year)	20.00	wie Sinnat	biter CE	nter ,	المالئ	nster h	rD	2115	7
		Sta Registr		31. Date filed (Month, Da	CT 2 2	2004	Elphus.	d.	Soul!		,			
			1											

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of			giene 00!	35480
	Physici		1. Decedent's Name (First, Middle, Last John B. Glude)				2. Date of Dea Month	th Day Yee	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of De	October	19 2004 4c. County of De	9.40
		Ħ	Ginger Cove Heal	th Center			Annapol	is		Arundel
	Funeral Director		330-10-0002	x 7. Age XM 2□F	(In yrs. last birthday 86 Yrs.	Months Days	If Under 24 H Hours M		, Year)	Birthplace (State or Foreign Country) ashington
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Marylia-f sho	ctor	Maryland Anne Ar	undel			polis			1 ☐ Yes 2√D(No
	3a or 26	i Dire	10e. Street and Number 4000 River Cresce	nt Drive		10f. Zip Code	21401		Og. Citizen of What U.S.A.	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show sayl figury or other traumatic evant. I're Madical Exertified at Ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3℃Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes ♣☐N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 X No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ai Black, W	merican Indian, hite, etc. White
21215-0036	hin 72 ho s. no "natur Modical	Completed	15. Decedent's Edd (Specify only highest grad	cation e completed) College (1-4or 5-	(Give	dent's Usual Occup kind of work done DO NOT use retired	nation during most of w d)	vorking	16b. Kind of Busine	ss/Industry
7	giene giene ar tha	Com		5+	Fish	eries Bic			Bio	Logy
Maryland	uld ba file Aental Hy rkad oth tic evant	To Be	17. Father's Name (First, Middle, Last) William T. Glud					nce M. Mc		
Mary	nd 2 shoulth and N 27 is ma		19a. Informant's Name/Relationship (7) Nancy Kelly/daugh	, . ,		ng Address (Street Riverview			r, City or Town, State s, Marylar	
altimore,	ages 1 a nt of Hea t: If item y or othe	i	20a. Method of Disposition 1 ☐ Burial ACCremation 3 ☐ F		-	osition (Name of matory or other place e Cremato		Date 25 / 2004	20c. Location - City	or Town, State
Baltin	permit. P Depertme Importan any Injury		4 □ Donation 5 □ Other (Specify) 21. Sign □ uneral rery e Licens		1// 2	2. Name and Addre	ss of Facility J		ylor Funei	
			23a. Part1. Enter the disease, or comp	ications that caused	the death. Do not en					Approximate
	Physician (Madical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Con from	Manuelar	accell	int.			Interval Between Onset and Death
P	/Medical Examiner		Sequentially list conditions.	b	consequence of):					
8760,	cate be executed physicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ō	consequence of).					
.O. Box 68	The law requires that the death cartifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3	Ectopic pregnancy	/		23d. Date of o	lelivery Day Year
Δ.	quires that n signad b uld be deta	d by Ph	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tol		to the cause of death? Probably 4 □Unknown
I Records,	The law requirate has been spage 2 should	Completed by		•				24a. Was a autops perform	y prior t	
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					eath (Check only on	е)	
of	ing Phys	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatier 28a. Date of Injur (Month, Day		f 28c. Injur Wor	y at		ence 6 Other (Sp ow injury occurred	Decify)
Division	I or Attending after death. Diractor: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (St City or Town		Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best on ner: On the basis of and manner state	f my knowledge, deal examination and/or in ted.	h occurred at the tir vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the co	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within To the compl	Me	29b. Signature and title of perfiling	NID		29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
			30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type	Print)	1 1		101/09	
			Datest Singh	Seller	eath (Item 23a) (Type,	rapoly K	bad to	tich odl	enton M	0 21113
	Sta Registr		31. Data filled (Month, Day, YOUT	2 2 2004 gistra	Bosse 1	& Speed				

				artment of Health and Mentartificate of Death	al Hygiene Reg. No. 2004	35481
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Emma Marie Hendershot	. Mc	te of Death onth Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	
	Formand		Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hagerstown If Under 1 Year If Under 24 Hrs. 8. Da	Washingt	
	Funeral Director		214-28-5793 1 M 2X F 77 Yrs.	Months Days Hours Min. (Mr.	ober 11,1927	irthplace (State or Foreign Country) MD
	pur M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryla f sho	ō	MD Washington Hancoc			1 ☐ Yes 2 No
٠	r 28a	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?
	23a c	raiD	14436 Hendershot Road	21750	UŞA	
	ier dez Itams ner m	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Specify Yell of Yes, specify Cuban, Mexican, Puerto Rican,	etc.) 14. Race - Am Black, Wh	
930	al', or	۾	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: W	hite
Maryland 21215-0036	filad within 72 hours after death with the Maryland Hygiene. Uthar than "natural", or Itams 23a or 28e-f show July the Madical Examinar must be molified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Busines	s/Industry
12	within ene. than '	junc	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) emaker	Own Home	`
<u>5</u>	illad Hygi othar	Be Co	17. Father's Name (First, Middle, Last)	·····	Middle, Maiden Sumame)	
<u>lar</u>	should ba and Mental s markad o umatic ava	To B	Bruce Hendershot	Sarah Patie	nce Hixon	
Jan	2 sho			ng Address (Street and Number or Rural Route		
	1 and Health Iam 27 othar ti		Samuel D. Hendershot/Son 7700 20a. Method of Disposition 20b. Place of Dispo	Old Battlerove RD B sition (Name of natory or other place) Date	20c. Location - City o	
altimore,	Pages nent of I int: if its iry or o		IX Bunal 2 Cremation 3 Chemova non State	ey Christian 11/06/04	Warfordsbur	о РА
= =	perriit. Pages 1 and 2 should ba filad within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is merkad othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic avant. The Madical Examinet must be notified at an once.			2. Name and Address of Facility	141 West Mai	
m ===	8258		That Thore G	rove Funeral Home, P.A	. Hancock, MD	21750-0368
1			Part I. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	020		Approximate Interval Between Onset and Death
	Pn ysicia n /Medical		disease or condition resulting in death) a. (1	UCTIVE PULMOWARY	DISEASE	257
	Examiner		A PTIC STENA	515		2. X
	D #	iner	if any, leading to immediate Due to (or as a consequence or):			37
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	E		57
8760,	ate be ex hysician the buria	dicai E	d.			
9	ntificate ng phys s as the	Medi	IF FEMALE:			
Вох	eath certific attending p I for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	23d. Date of de Month	elivery Day Year
О	that the de led by the a detached t	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Tottler (specify)		
	res that signed b be deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23	e. Did tobacco use contribute t	to the cause of death?
ord	w raquire baen sig should b				1 Yes 2 No 3 P	robably 4 SUnknown
Division of Vital Records,	2 2 2	Completed		24	a. Was an autopsy performed? 24b. Were a prior to death?	utopsy findings available completion of cause of
<u>a</u>	rsician: The law s certificate has b lirector, page 2 s	0	25. Was case referred to medical	1 C 26. Place of Death (Chec	Yes 2 No 1 Yes	s 2□ No
Ž	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2 No Hospital: ☐Anpatient 2 ☐ ER/Outpatien	Other	☐ Residence 6 ☐ Other (Spe	ecify)
0 =	Attanding Physician: r death. actor: After this certifics by the funeral director, i		27. Manner of Death 1 ☐ Patural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury Injury	Work?	escribe how injury occurred	
Sio	ttandideath.	icati	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Injury 4t home farm str	M 1 Tyes 2 No	cation (Street and Number or R	lura / Route Number
<u>≥</u>	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	4 Homicide determined building, etc. (Specify)		y or Town, State)	
	To tha Hospital or A within 24 hours after To tha Funaral Dira completely fillad in b	dical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in			
	tha H hin 24 tha F	Medi	one) and manner stated.	29c. License number	29d. Date signed (Mon.	
·	Z Wil		29b. Signature and title of certifier	D 52323	11/4/04	, say, roar,
	"		30. Name and address of person who completed cause of death (Item 23a) (Type,			
		-	Dy Waseem 1126 upal Com	of Hoy Md	21742	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2004	park		
		7	NUV U 3 LUUT /			

		L	For State Registrar	State of Ma	ryland / Depa		lealth and M	lental Hyg		35482
	Physici /Medio	cal	1. Decedent's Name (First, Middle, La: Charles	Aud	Hab		or Location of Death	2. Date of Deat Month Oct •	Day Year 20, 2004 4c. County of Deat	3. Time of Death 3:50 PM
	Examir Funeral Director	ner	400-10-0752	g and Reha	(In yrs. last birthday)	If Under 1 Year Months Days	Salisbui If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/04/1	Wicomic	
	e Maryland 3e-f show	ctor	-	comico	10c. City, Town or Lo	ury				10d. Inside City Limits 1 Yes 2 No
	ath with the 23 or 23 or 23 or 24 or 24 or 25 or	rai Dire	10e. Street and Number 200 Civic Ave			10f. Zip Code 218			0g. Citizen of What Co	
036	ers after de er, or tems Exerciter in	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3X Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	0	Was Decedent of F If Yes, specify Cuba 1 Yes 2 No	tispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Medical Exer in air trust be inclified at	Completed by Funeral Director	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work.	ing	16b. Kind of Business/ Hercules,	
land 2	uld be filed Mental Hygi Irked other Itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Frank L. Habic			9111001	18. Mother's Name Genero	First, Middle, M		THC.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23s or 28e-f show any filery or other treumatic event, the Mydical Exam if art must be notified at one.		19a. Informant's Name/Relationship (Virginia E. Ha 20a. Method of Disposition	bich/dau	ghter 2.	311 Pine	eway, Sa	lisbur	City or Town, State, 2 MD 218 20c. Location - City or	0 4
Baltimore,	permit, Page Department of Importent: If any injury or		1 XBurial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	y) nsee	Rivervie		10/2 §°Fünera	l Home		onal Assoc
No. of Street, or other Persons	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. In 1-	the death. Do not entered the death. Do not entered the death. Do not entered the death of the d	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
760,	te be executed system and se burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	onsequence of):	an				y M-
.O. Box 68	death certifica e attending phy od for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3	Ectopic pregnancy	у		23d. Date of del Month	ivery Day Year
٦	es De	by	Part II. Other significant conditions of	contributing to death bu	it not resulting in the u	inderlying cause giv	ven in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	the cause of death?
I Records	The law ate has b page 2 sl	Completed						24a. Was a autops perform 1 Yes 2	v prior to d	itopsy findings available completion of cause of 2 No
f Vital	Physician: The this certificate ral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 470	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3□ DOA Oth	26. Place of Death		e) ance 6 🖺 Other <i>(Spe</i> d	cify)
Division of	tending leath. tor: After the fune	Certification:	27. Manner of Death 1 □ Matural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	e 200 Place of Inju	y Year) 28b. Time o Injury	M 1□	rk? Yes 2□No		w injury occurred reet and Number or Ru	ıral Route Number.
DIV	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	dical Certif		building, etc	: (Specify) of my knowledge, deat	h occurred at the tir			use(s) and manner as	
)	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner sta		29c. Licens			ed. Date signed (Montl	
JA	2		30. Name and address of person who William H-Ro	completed cause of de	eath (Item 23a) (Type,	Print)	200 Civic	Ave.,Sa	lisbury, M	d. 21804
Y	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 2 21		r's Signature	Spark	2			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiena 35483 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:12 Jr. October 20, 2004 Holland Norman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1105 S. Salisbury Schumaker Drive Wicomico If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**∑**M 2□ F 82 Yrs. 4/08/1922 Maryland 218-16-5132 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location with the Maryland 10a. State 10b. County or items 23a or 28a-f show the Medical Examiner rount be notified at 1 X Yes 2 □ No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1105 S. Schumaker Drive 21804 USA death v by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Item 27 Ie marked other than "natural", or ite ury or other traumatic event, the Madical Examina 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo Specify: white Maryland 21215-0036 Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Concrete & Building Elementary/Secondary (0-12) College (1-4or 5+) Materials Owner/operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Grace Thomas Sorin Norman Holland Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cheryl H. Brenner/daughter 444 Rolling Rd., Salisbury, MD 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or 10/23/04 Parsons Cemetery Salisbury, MD * 4 □Donation 5 □ Other (Specify) ture of Funeral Service Licensee Professional Associated Holloway Funeral Home Professional Associated Holloway Funeral Home Professional Associated Home Profession Hom 21. Sign 501 Snow Hill Rd., Salisbury, MD 21804 Payl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate as Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day į 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 99 2 🖪 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No has page 2 1 Yes ate Division of Vital 25. Was case referred to medical examiner? Hospital or Attending Physician: certific Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After Certification: Injury 1 Natural 5 Pending investigation M 1 TYes 2 TNo death. 2 Accident **Director:** 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0470 94 10/2/104 NIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISAURY MD 2,804 5. DIVISION NATESAN 1415 STREK vel 31. Date filed (Month, Day, Year) 0CT 2 2 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 35484 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month October **Physician** 22, 2004 RUTH MILLER HURT 6:20 a M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | NoV • 22, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 80 Yrs. Virgínia 225-24-3383 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County rel', or Items 23e or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Prince George's Laurel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20708 13300 Deerfield Road, Apt. 101 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White ģ 3 N Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Singer Link, Inc. 5 Electronics Tech 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 2008. Be Edward Miller Viola McDaniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald S. Hurt Sr. - Son 13300 Deerfield Road, Apt. 101, Laurel, MD <u>20708</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🎇 Burial 2 🗆 Cremation 3 🗆 Removal from State ^ 4 □Donation 5 □ Other (Specify) Fort Lincoln Cemetery 10/27/2004 Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Ave., Hyattsville, MD 20781 Maul 1 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Normal Pressure Hydrocephalus /Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Anemia Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed? certificate 1 ☐ Yes the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? __ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA P After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

15

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

11701 Roby Avenue, Beltsville, MD 20705 Joselito D. Magday, MD 31. Date filed (Month, Day, Year) OCT 2 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, mus

DHMH 17 Rev 1/2001

29c. License number

D013687

29d. Date signed (Month, Day, Year)

October 25, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4 35485 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3:45PM 04 Alma J, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Center Cheverly Months Days Hours Min. B. Date of Birth Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 ☐ M 2 🕮 F 63 Yrs. 577-54-9844 Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Fairmount Heights Prince George's Maryland 1 M Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 U.S.A. 1019 58th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 24 No Specify: Specify: Black 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Dept. Of Labor (Retired) Arditor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dorothy A. Murphy Charles H. Lynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11434 Laurel Bowie Road Bowie, Maryland 20708 19a. Informant's Name/Relationship (Type, Print) Lynne Hall (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 10/26/04 Beltsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature y Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. Part . Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reulatory Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

Examiner or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, After this death. Director: filled in by within 24 hours after To the Funerel Dire

physician a s the burial-t the

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2: Department of Health at Important: If Item 27 is eny injury or other trac

Physician /Medical

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Directo

Completed by Funeral

State

Physiclan/Medical þ Completed Certification: To

Medical

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**EXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature, and title of certified

29c. License number D0061106 29d. Date signed (Month, Day, Year)

Tyoti Chandrakant Jugtap MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wend ausseneberry Bowce AM 31. Date filed (Month, Day, Year)

2 6 2004



DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** HENRY October 22 AGNES 2004 AM 6:55 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Cherry Lane Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2⊠ F Yrs. 213-58-8913 1920 Maryland Director March Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Dapartmant of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director Prince George's Laurel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20724 U.S.A. 226 Sweet Pine Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Š 3 XWidowed 4 Divorced **Black** Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Domestic Private 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simon Ross Estelle Chew 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Joseph H. Daniels /Son 226 Sweet Pine Drive Laurel, Maryland 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/04 Landover, Maryland Harmony Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical Abdominal Cancer Examiner Due to (or as a consequence of) Examine Diabetes raquiras that the death cartificate be axecuted attanding physician and for usa as the bunal-translt Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Hypertension Physician/Medical Due to (or as e consequence of): signed by tha a Id ba datachad f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown \$ 24b. Were eutopsy findings available prior to cartificata has baan si fractor, paga 2 should 24a. Wes en autopsy performed? Completed completion of cause of deeth? Tha 1 ☐ Yes 2√2 No 1 ☐ Yes 2/ No Hospital or Attending Physician: erel Director: Aftar this cartific fillad in by the funeral director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 🔀 No 2 ☐ ER/Outpetient 3 ☐ DOA 27 Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNaturel 5 Pending investigation 1 Tyes 2 No death. 2 T Accident 6 Could not be determined 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital
within 24 hours a
To the Funeral C 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.
2 Medice Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of of person who completed cause of deeth (Item 23a) (Type, Print) John M≨rgolis 13952 Baltimore Avenue Laurel, Maryland 20707 M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 6 2004

DHMH 16 Rev 6/95

Registrar

ORIGINAL

			1 - State Registrer	of Maryland /	-	rtment of He tificate of D			ene2004	35487
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		MARY A.	HOBBS				October	$22^{\text{Day}}, 200^{\text{Ye}}$	11:45 PM
	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or L			4c. County of Dea	
			Friends Nursing Home				Spring If Under 24 Hrs.	0.0	Montgom	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last to	birthday) _ Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	rear) C	thplace (State or Foreign
	Director		Usual Residence of Decedent	93				Jan. 9,	1911 Was	hington,D.C.
	yland now		10a. Slate 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
	a-f st	tor	Md. Montgomery	Silve	er Sp	ring				1 ☐ Yes 2 MNo
	th the	Director	10e. Sireel and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
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	ar de i	Funeral	Armed	ecedent Ever in U.S. Forces?	13. W	as Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
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2-0036	n 72 hours after death with the Marylan "natural", or items 23a or 28a-1 show catcal Examinar must be mulified at		15. Deceden!'s Education	16	6a. Decede	enl's Usual Occupat	ion		6b. Kind of Business	/Industry
22		Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	life. D	ind of work done du O NOT use retired)	iring most or worki	ng		
7	filed wit Hygiene Sther the	Con	12 0		Hom	emaker			Own Home	
and		Be	17. Father's Name (First, Middle, Last)			1		(First, Middle, Ma	aiden Sumame)	
<u> </u>	2 should be and Mental 'Is marked raumatic ev	2	Thomas Sweeney		-1 -1 -11		Barbara			7.011
Ma	12 sh h and 7 is m Iraum		19a. Informant's Name/Relationship (Type, Print) Charlotte H. Kirk / Da	i	-	Gamewell			City or Town, State, . ring, Md.	
o,	1 and Healt em 2 ither		20a. Method of Disposition	20b. Place	of Dispos	ition (Name of	! 0		Dc. Location - City or	
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saltimore,	artme ortan	1	21. Signature of Funeral Service Licensee			Name and Address Muriel H.				ing, na.
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		> murief H. Barle			Muriei H. P. O. Bo	x 5038,	Funerai Laytonsv	ноте ille, Md.	20882
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	/Medical		reculling in death)	lo (or as a consequence	ce of):		Y			
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	ed isit	nine	cause. Enter Underlying Cause (Disease or injury	o (or as a consequence	201).					
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X R R	leath certifica attending ph I for use as t	cian/Me	230. Was decedent pregnant	outcome of pregnancy e birth 2 Fetal dear	ath 3 ⊡8	Ectopic pregnancy			23d. Date of del Month	livery Day Year
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Į.	w requires that the de been signed by the should be detached	₾	Part II. Other significant conditions contributing to	death but not resulting	a in the unc	derlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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DIVISION	al or Attending after death. I Diractor: After d in by the fune	ertification;	data mined 286. Pl	ace of Injury - At home, ilding, etc. (Specify)	, tarm, stre	et, factory, office		City or Town,	et and Number or Ru State)	ural Houte Number,
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	e Hos 24 h e Fur letely	edical	(Check only 2 Medical Examiner: On Ih	e basis of examination a anner stated.	and/or inve	estigation, in my opin	nion, death occurre	ed at the time, date	e and place, and due	to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the to	Me	29b. Signature and little of certifier			29c. License r	number	290	d. Date signed (Monta	h, Day, Year)
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	•		30. Name and address of person who completed c	ause of death (Item 23a	a) (Type, P					
			DENNIS M. HANNON I 31. Date filed (Month, Day, Year) 32	D 2901 (DLIVE	Y-SANDY	SPRING	RUAD (PLNEY, W	PARYLAND
	Sta Registr		OCT 2 5 2004	Percusal Sagriature	9	Sparks	/			

			For State Registrar	State	of Marylan		artment of H		and M		giene Reg. No	1001	35	. 88
			Decedent's Name (First, Midd	le, Last)						2. Date of Dea		. 0 0 7	3. Time	of Death
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	/Medio Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of		occoper		. County of D		J
	LAdiiiii	C1	Carroll Count	v General	Hospita	1	West	minst	er			Carro	11	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da	h Voarl	9.1	Birthplace (Sta	e or Forei g n
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	p ,		Usual Residence of Decedent		10a Cib	, Town or Lo							10d Jacida	City Limits
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Maryland 21215-0036	"naturel",	edt		nt's Education	Jaios.	16a, Dece	dent's Usual Occupa	ation			16b. K	and of Busine	ss/industry	
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	es 1 and 2 should b of Heelth and Ment if item 27 is markad ir other treumatic		Mary E. Thomps	on/ Daugh			Gillis R	oad,	Mt.	Airy, N	1D 2	1771		
ore	- Se Tito		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	State 20b. P	lace of Dispo empetery, crer	sition (Name of matory of other place Of Heaven	e) (Octob	8er 26		·	or Town, State	
Ĕ	Pag ment ant: I		`4 □Donation 5 □ Other (- Oldio	Cem	etery		200				ring, Ma	ryland
Baltimore,	permit. Pages 1 Depertment of F Important: If ite any injury or of once.		21. Signature of Funeral Service	Doden		50	rancis Addres 00 Univer	sity	Blvd	, W, Si	lve	me Inc r Spri	ng, MD	20901
			23a. Part1 Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the death	Do not ent	er the mode of dying	g, such as	cardiac o	r respiratory ar	rest.		Approxin Interval I	Between
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387	phys phys s the	dical		d										
9 X	the death certificate y the attending phys tched for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome of pregna	ncy						23d. Date of o	delivery	
Вох	leath atter	Physician/M	in the past 12 months?	4□Preg	birth 2 ☐ Fetal nant at time of de		Ectopic pregnancy Other (specify)					Month	Day	Year
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Division	al or Attendin sefter death. I Director: Af d in by the fur	Certification		nined 286. Plac	e of Injury - At ho ling, etc. (Specify	me, farm, str	eet, factory, office		2	8f. Location (S City or Tow			Rural Route N	umber,
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	To the Hospital or Attenwithin 24 hours efter deat To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the l Examiner: On the l and mar	e best of my know basis of examinat nner stated.	ion and/or inv	occurred at the tim restigation, in my op	e, date and pinion, deat	d place, a h occurre	and due to the c ad at the time, c	ause(s) date and	and manner I place, and d	as stated. lue to the cause	e(s)
	To the within To the Comp	Ž	29b. Signature and title of certific	er C)		29c. License	number		2	29d. Dat	e signed (Mo	onth, Day, Year)
)	4		HAJUEN	DOLO O	/ M	1.17	D25	505	2		12	1/23	104	
	-		30. Name and address of person	who completed cau	ise of death (Item		Print)	341	TE	102		ough	YGS N	11265
			HAFEEZ	H 548		21 01	KOSSRU	700	7	KIVE	/ -	MD.	2111	7
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			1 = For State Registrar	ate of Ma	ryland / [nent of F	lealth and l Death		giene 0 ()4	35489
		Ш	Decedent's Name (First, Middle, Last)						2. Date of De		Year	3. Time of Death
	Physici /Medio		Doris Gwendoline		Hamli				OC^{Month}	21 2	004	6:45p M
	Examir	er	4a. Facility Name (If not institution, give street CIVISTA MEDICAL		?		City, Town, o JAPLAT	r Location of Deat 'A	h	4c. County	of Death RLES	
	Funeral Director		5. Social Security Number 216 38 6338 6. Sex 1 □ M 2		(In yrs. last bir 79		Inder 1 Year oths Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Jan 3,	th y, Year) 1925	9. Birthp Cour Engl	place (State or Foreign atry) and
_	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locatio	n				1	0d. Inside City Limits
	Mary -f sho	ţo	Maryland Prince Geor	ge's	Upi	oer Ma	rlboro					1 ☐ Yes 2 ☐ No Y Y
	th the or 28e e noti	Director	10e. Street and Number				of. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	ath wi		15306 Gray					772		United		
98	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene. Sa or 28e-f show any injury or other traumatic event, It a Meulcal Exp. riter can be notified at once.	by Funeral	1 Never Married 2 Married 1	as Decedent E med Forces? Yes 2 XX Yes, Give har or Dates:		If Yes	Decedent of H s, specify Cuba res 2 12 140	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)		k, White,	an Indian, etc. White
	2 hours	ted t	15. Decedent's Education		16a.		Usual Occup			16b, Kind of Bu	siness/In	
, \(\) 21215-0036	within 7. ene. than "n	Completed	(Specify only highest grade complete (0-12)	oleted) ollege (1-4or 5-		life. DO N	OT use retired	during most of word)	rking	0		
	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)			omemak	er	18. Mother's Nar	me (First, Middle,	Maiden Sumam	Home	
Ham!	Menta Menta Brked atic ev	ToB	Frank Mills						Ellen C			
1	12 sho		19a. Informant's Name/Relationship (Type, Pr Edward Rogers (Son			_		and Number or Ru		-		·
	1 and Health Iem 2		20a. Method of Disposition									yland20772
Serio	Pages lent of nt: If if		1 ☐ Burial 2 ☐ Xremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	Mafÿïa Lee Cr	nd™√e emato	terans rv Oct	"Cem. Oct 23. 2004	28,200	4Clinton	nham, 1, Ma	Maryland ryland
	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	L M	00153	22. Na	ne and Addre	ss of Facility Lee	Funera	1 Home,I	nc 6	633 Old
	Section 1		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused	the death. Do r							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	luon	uc a	060	wel	UE P	Muon	aug Di	isella	Onset and Death
	/Medical Examiner		resulting in deality	Due to (or as a	consequence	of):				1		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	of):						
	cate be executed physician and the burial-transit	Examiner	that initiated events c	Due to los es e	consequence	-f).					-4	
8760	cate be ex physician a the burial		Tooling in double, and	Due to (or as a	consequence	or);						
687	tificate og phys as the	edical	d									
Š	eath certifi attending for use as	an/M		res, outcome o	of pregnancy 2 Fetal death	3 □Ecto	pic pregnancy			23d. Date Mor	e of delive	ry Day Year
Division of Vital Records P.O. Box	that the dea ed by the at detached fo	Completed by Physician/M	1 Vac 2 Dalla	Pregnant at t	time of death	5 🗆 Oth	er (specify)			Mor	iui	Day feat
<u> </u>	signed d be det	d by P	Part II. Other significant conditions contributions	ng to death bu	t not resulting in	the underly	ving cause give	en in Part I.	1			e cause of death?
j	aw requir s been s 2 should	lete	mile charges.	P				-	24a. Was		Vere autor	osy findings available
B	The la	ome	0 3 00 30						autop perfo	rmed2 d	rior to cor eath? Yes	npletion of cause of 2 No
ita.	ysician: Th	Be	25. Was case referred to medical examiner?	1.			104	26. Place of Dea	ith (Check only o	ne)		
5	Physical direction	-: To	1 ☐ Yes 2 ☐ No Hospita 27. Manner of Death 28a	. Date of Injury	y 28b. 1	tpatient 3	DOA Other	4 🗆 Nursing n		lence 6 Othe)
i	ttending Ph death. ctor: After thi / the funeral	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) II	njury N		k? Yes 2 □No				
Divis	ei or Atte s after de ii Directo d in by th	Certification:	3 Suicide 6 Could not be determined 286	. Place of Injur building, etc.	ry - At home, fa . (Specily)	rm, street, f	actory, office		28f. Location (5 City or Tox	Street and Number m, State)	er or Rura	Route Number,
	To the Hospitei or Attending Physician: The law requires that the death certification 24 hours after Alex this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: O	To the best of n the basis of nd manner stat	examination an	, death occi d/or investig	urred at the timation, in my of	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and mar date and place, a	nner as st nd due to	ated. the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier	- H.D			29c. License			29d. Date signed	1	Day, Year)
			1) /	ed cause of de	ath_(Item_23a) (Type, Print)		056949		10/22	104	
4	DB5		BAIC, KAMAKSHI, M	ID 66.	20 CRÁ	IN H	IGHWAY	SUITE	102 WA	LDORF,	MD	20646
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 6 2004	32. Rojistrai	r's Signature	April	A. S.					

	1 - For State Registrar	State of Maryland / Depa Cei	artment of Health and M rtificate of Death	fental Hygien Reg. N	e 2004 35490
Physician (Madical	Decedent's Name (First, Middle, Last) Roy McLean	Haynes		2. Date of Death Month October	3. Time of Death 21, 2004 4:00 P M
/Medical Examiner	4a. Facility Name (If not institution, give str 14800 Dunbarton I	rive	4b. City, Town, or Location of Death Upper Marlboro	F	c. County of Death Prince George's
Funeral Director	230-14-8263	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Apr 13, 1	9. Birthplace (State or Foreign Country) 922 Virginia
e Maryland sa-f ehow ilitied at	Usual Residence of Decedent 10a. State 10b. County MD Prince	George s Upper M	Marlboro		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
h with the Mar 3a or 28a-f e at be matified at Director	10e. Street and Number 14800 Dunbarton I	rive	10f. Zip Code 20772	10g. C	Citizen of What Country? USA
ire, Maryland ZIZID-UU30 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If health and Mental Hygiene, other traumatic event, the Maxical Exaculture routs be natilised at To Be Completed by Funeral Director	11. Marital Status 12 1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces? 1771Yes 2 □ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【※No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Z I Z I 3-U ed within 72 ho ygiene. nor then "natur. nor the Mulcal I t, the Mulcal I	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Completed) (Give life	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Chant Marine	ing 16b.	Kind of Business/Industry Maritime
land in the filed be filed be filed be filed by the debta land land land land land land land lan	17. Father's Name (First, Middle, Last) Herbert Lee Hay	mes		e (First, Middle, Maide	
Mary d 2 shouth and h th and h th and h treumat	19a. Informant's Name/Relationship (Type Betty Haynes (Wif	1	ng Addrass (Street and Number or Rur Dunbarton Drive	1.2-300	or Town, State, Zip Code) 1boro MD 20772
altimore, M mit. Pages 1 and i partment of Health portent: if Item 27 y injury or other fr	20a. Method of Disposition 1 Burial 2 Cremation 3 Rec 4 Donation 5 Other (Specify)	20b. Place of Dispo	esition (Name of matory or other place)	Date 20c.	Location - City or Town, State Linton MD
Baltimory permit. Pages Department of t Important: If tie eny injury or of	21. Signature of Funeral Service Licensee Gary J. Goff	22		ee Funeral	Home Calvert, PA
Physician	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do not ent cause on each line.		or respiratory arrest,	Approximate Interval Betwaen Onset and Death 2 Years
/Medical Examiner	resulting in death)	Due to (or as a consequence of):			
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that indiated events c.	Due to (or as a consequence of):			
cate be executed physicien and the burial-transit clical Examir	resulting in death) Last	Due to (or as a consequence of):			
death certification of for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, F es tha igned be del	Part II. Other significant conditions control Coronary	abuting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	ouse contribute to the cause of death?
II KECOTGS, The law requires to take has been signe page 2 should be Completed by	Hyperter			24a. Was an autopsy performed?	
	25. Was case referred to medical	Fibrillation		1 Yes 2X N	lo 1 Tyes 2 No
on of ding Phys. After this funeral d	1 ☐ Yes 2 📆 No 27. Manner of Death 1 📆 Natural 5 ☐ Pending 2 ☐ Accident investigation	spital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time o		me 5 X Residence 28d. Describe how inj	
DIVISION Control to the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After to the Funeral Director: After to the Funeral Director: After Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
To the Hospit To the Funers completely fills Medical (29a. Certifier Check only one) Certifying Physical Examine	cian: To the best of my knowledge, deat er: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause(red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To the within 2 To the complete	29b. Signature and fitte of certifier	May MD	29c. License number DO003792		Date signed (Month, Day, Year)
D+1	30. Name and address of person who com Irnest Oser, MD	releted cause of death (Item 23a) (Type, 10301 Georgia Aver	Print)		et 25, 2004
State Registrar	31. Date filed (Month. Day, Year)	32. Registras Signature 2004 Straws &		2000	-

DHMH 17 Rev 1/2001

04 - 7058Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, 27...per ME_CR38 12/18/04 TT B.K.S State of Maryland Department of Health and Mental Hygier () 35491 MICHAEL JONES 1 - For State Registrar Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Michael Jones 2004 6:00 P M NOV. /Medical 4a. Facility Name (If not institution, give street and number)
1328 MAIN CHAPEL WAY 4b. City, Town, or Location of Death CROFTON 4c. County of Death
ANNE ARUNDEL Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 13, 1951 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 10XM 2□ F Months Days Hours 213-58-1907 Yrs 53 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No York Glen Rock Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5019 17327 U.S.A. Hildebrand Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Salesman Distribution Pages 1 and 2 should be filed went of Health and Mental Hygisent: If item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reba Berlin John William Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5019 Hildebrand Rd., Glen Rock, PA 17327 Debra Walker-Jones Date 5, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Yorktowne
Cremation Service 20c. Location - City or Town, State 20a. Method of Disposition Nov. 5 1 ☐ Burial 2 X Cremation 3 X Removal from State Department of Importent: If eny injury or once. York, PA Service 2004 * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Atherosclerotic Cardiovascular Disease resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 certificate 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 X Other (Specify) AT SCENE 1 XYes 2 □ No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident

Division of Vital Records, Hospitel or Attending Physicien: After thi within 24 hours after death. To the Funerel Director: A filled in by To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and une to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E NOV. 2, 2004 KORSU MANYSMOS completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Ma 111 Penn Street, Baltimore, Maryland 21201 barre

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year) NOV 0 9 2004

3 Suicide

29a, Certifier

Medical

4 Homicide

6 Could not be determined

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Reg. Nø.

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on of Vital Records, P.O. Box 68760,	the Obviolation. The four sequires that the death continues be executed
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1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician JONES** October 2004 25 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner DOCTOR'S COMMUNITY HOSPITAL PRINCE GEORGE'S
1938 9. Birthplace (State of LANHAM 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) 6. Sex Funeral Months Virginia 1⊠M 2□F 66 September Director 227-44-2525 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Prince George's Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 5417 Henderson Way 20746 items 23a U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married ò 1 ☐ Yes 2 ☑ No Specify: Š Specify: Black. 3 ☐ Widowed 4 ☐ Divorced 2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Private 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Woodrow Jones Bernice Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trav once. 5417 Henderson Way Suitland, Maryland 20746 Jacqueline D. Baker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-30-04 ' 4 ☐ Donation 5 ☐ Other (Specify) Dinwiddie Memorial Dinwiddie, Virginia 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee . D 7474 Landover Road Landover, Maryland 20785 22a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ANTERIOS CIENOTIC CANDIOVASCULAN DISCOLAN Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? PERIPHENAL VASCULAR DISPERT 24a. Was an certificate has page 2 autopsy Diabetes Mellitus 1 Yes 2 No 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Mospital or Attendin 24 hours etter death. Funeral Director: Att 1 ☐ Yes 2 ☐ No Divisio 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 001852 October 25, Zooy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Queensbury Rd Hyattow, He MA 2078) DEVURE MD 4203 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 7 2004

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Depart	tment of Health and Mer	ntal Hygien	2001	35493
			1 - State 11-1-04 Registrar America #5.Per Fam.PCC cr Certif	ilcale of Dealif	Reg. N	. 004	
9	Physicia		1. Decedent's Name (First, Middle, Last)		Date of Death Month Da	ay Year	3. Time of Death
	- /Medic		Welford Hiram Jackson, Sr.			23 2004	0725 M
	Examin	er		b. City, Town, or Location of Death	46	c. County of Death	
			Montgomery General Hospital	Olney If Under 1 Year If Under 24 Hrs. 8	Date of Birth	Montgo	
	Funeral		7373 1X M 2 D F	Months Days Hours Min.	(Month, Day, Year ot. 24.		lace (State or Foreign try)
	Director		579-60- 7323		1903 V1	rginia	
	yland		10a. State 10b. County 10c. City, Town or Locat	tion		11	0d. Inside City Limits
	a-f.s	ctor	Maryland Montgomery	Silver Spring			1 XYes 2 No
	or 28)ire	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Coun	try?
	23a	rai	2207 Solmar Drive	20904		United St	
	r dea	nue	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa Armed Forces? 13. Wa	s Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.)	 Race - America Black, White, etc. 	
36	s afte	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Swidowed 4 Divorced Year or Dates:	Yes 20 No Specify:		Specify: Bla	ack
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23a or 28a-f show than Pedical Examinat must be notified at	edt	4	nt's Usual Occupation	16b. J	Kind of Business/Ind	lustry
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212	e filed within al Hygiene. I other than ' vent, the Me	mo	4	Teacher	I	O.C. Publi	ic Schools
b	be filled tal Hygie d other event, I	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	rst, Middle, Maide	n Sumame)	
<u>la</u>	should be nd Mental s marked umatic ev	To	Eugene Ferdinand Jackson		Kate Sel	.don	
Maryland	2 shoul t and Me is mari raumati			Address (Street and Number or Rural Ro			
	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. I'm Medical Evantinar must be notified at		20a Method of Disposition 20b. Place of Dispositi	7 Solmar Dr., Silve		ocation - City or To	
Baltimore,	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	tory or other place) emorial Cem. 10/30/			
Ħ	무원활동 .					Suitland, neral Home	
Ba	permi Depa Impo any il			4001 Benning Rd., N			0019
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, on heart failure. List only one cause on each line.	the mode of dying, such as cardiac or re	spiratory arrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	LAGITITIES	<u>_</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
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Ć,	te be executed ysician and te burial-transit	Еха	that initiated events resulting in death) Last				
68760,	ate be executed hysician and the burial-transit	ical	d				
89	death certificat e attending phy d for use as th	Med	IF FEMALE:		- T		
Вох	ath ce ttendi	lan/I	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ec	ctopic pregnancy		23d. Date of delive Month	ry Day Year
0.	0 00 0	Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5 O	Other (specify)			,
<u>α</u>	The law requires that the de ate has been signed by the a bage 2 should be detached I		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
ds,	uires n sign ild be	d by	Diabetes Mellitus		1 ☐ Yes 2	2 □ No 3 □ Proba	ably 4 Unknown
Record	tw requir s been s should	ompleted	Congestive Heart Failu	re	24a. Was an	24b. Were autop	osy findings available
Re	The lav	ome	7		autopsy performed? 1☐ Yes 2☐ N	death?	npletion of cause of 2 No
Vital		Se C	25. Was case referred to medical	26. Place of Death (C		•	
fν	ys Si Gi	To B	examiner? 1 Yes Thought all the patient 2 ER/Outpatient	3 □ DOA Cther: 4 □ Nursing Home	5 Residence	6 ☐Other (Specify)
n of	ding Ph h. After th funeral	:uo	27. Manner of eath 28. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	Describe how inju	ury occurred	
Sio	death. death. ctor: A y the fu	cati	2 Accident investigation	M 1 Yes 2 No	Landing (Compt.)	nd Number or Rura	1 Courte Marie has
Division		Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, street building, etc. (Specily)	t, factory, office 251.	City or Town, Star		House Washber,
	spita nours neral / filled		29a. Certifier Certifying Physician: To the best of my knowledge, death or				
	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in L	edical	(Check only 2 Medical Examiner: On the basis of examination and/or invesone)	stigation, in my opinion, death occurred a	it the time, date ar	nd place, and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title occertifier	29c. License number		ate signed (Month, L	
Δ.			NVILLAMAN J. IVINGLA	D 42 82		etoler o	, au 4
4	-(9)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	"Blvd #113, 8	ilvers,	ring, r	nd 20901
	Sta Registr		OCT 2 7 2004 Registrar's Signature	E			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	nd / Dep	artment of F	lealth and			35494		
			Hegistrar Decedent's Name (First, Middle, Las	it)		Timoate of	Dealin	2. Date of Death	g. No.	3. Time of Death		
П	Physici		Alton Nathan	iel Jones	5			Month 10	Day Year			
	/Medic Examin		4a. Facility Name (If not institution, give		 	4b. City, Town, o	r Location of Dea		4c. County of Dea			
			Peninsula Legione	I redical (enter	Salis	SOUN		Wiconico			
	Funeral		5. Social Security Number 6. S	Pru and	s. last birthday	Months Days	If Under 24 Hrs Hours Min	(Month, Day,	Year) 9. Bi	rthplace (State or Foreign Country)		
	Director		214-36-5727 Usual Residence of Decedent	65	Yrs.			May 29	1939 Ma	aryland		
	land ow		10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits		
	Many a-f sh	tor	Maryland Wicom	ico	Salis	bury				1 ☐ Yes 2XNo		
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?		
	23a c	alc	505 Robinson S	treet		2180			U.S.A			
	tems	nuel	11. Marital Status	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (: an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh			
36	rs afte	by Funeral	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: B	lack		
o	2 hou	t pai	15. Decedent's Ed	. 1	6b. Kind of Busines							
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f show ant, the Medical Examinar must be notified at	Completed	(Specify only highest gra	orking								
	gen with ser the	Con		College (1-4or 5+)	L	aborer			None			
nd	be fill d oth even	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M	aiden Sumame)			
<u></u> ₹	i Men narke natic	ပ္	Alton James Jo 19a. Informant's Name/Relationship (1)		105 Mail	in - Address (Ctmat	Lucy	Jones Pural Route Number,	City of Town Ctate	Tin Code)		
Maryland	d 2 sh th and th is r traun		Barbara Jones (•				alisbury		· i		
	Heal Heal tem 2		20a. Method of Disposition		Place of Disp	osition (Name of			Oc. Location - City o			
m 0	Pages nent of ant: If i		1 Burial 2 Cremation 3 □ 14 Donation 5 Other (Specify	Removal from State		matory or other place ill Mem.	1	ic/15/c4 2	Hebron,	4d.		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	_	2	2. Name and Address Stewart *21 West	ss of Facility Funera	l Home lisbury,	Md 21801			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the de-						Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	FAST	PIC	CA	NCE	12		Onset and Death		
•	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):							
	LAGIIIIII	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	guence of):							
	ned in sit	Examiner	cause. Enter Underlying Cause (Disease or injury		.,.							
ó	cate be executed physician and the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
8760,	ate be hysici the bu	dical	(d								
9		a	IF FEMALE:	OZa li voa autooma oi pro-								
Вох	w requires that the death certif been signed by the attending should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging 1 Live birth 2 Fe	tal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	olivery Day Year		
o.	the de y the iched	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	302(1)							
S, D	s that ned b	by Pl	Part II. Other significant conditions of	ontributing to death but not re	sulting in the o	ınderlying cause givi	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?		
rds	quire en sig ruld b							1 🗆 Yes	2 □ No 3 □ P	robably 4 20nknown		
Vital Record	law requires that the as been signed by th 2 should be detache	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of		
Œ	The ete h page	Com						performe	ed? death?			
/ita	Physician: The lav this certificete has ral director, page 2.	Be	25. Was case referred to medical examiner?	Manaital		0.4		ath (Check only one,)			
of	Physi this c	10	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie		4 Nursing I	Home 5 Residen		ecify)		
on	fune fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2□No	280. Describe flow	rinjury occurred			
Division	Atten r deat sctor: by the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, st	reet, factory, office		28f. Location (Stre	et and Number or R	ural Route Number,		
ā	rs afte rs afte al Dire	Certification:	4 Homicide	building, etc. (Spec	ary)			City or Town,	Siale)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kr iner: On the basis of examir and manner stated.	nowledge, deal nation and/or in	th occurred at the tim ivestigation, in my of	ne, date and place pinion, death occi	e, and due to the cau urred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)		
	To the within To the comp	Σ	29b. Signature and title of certifier	An 1		29c. License	number a 2 21	. 290	d. Date signed (Mon	th, Day, Year)		
			14111111	149/0	~	12	140		10/2	0/2004		
			30. Name and address of person who of Jimmy TAYLOR M.				und		/			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	1	y me					
	Registr	ar	OCT 2 5 2	JU4 Denew	0	spork						

Actor James 214-31-5727

State of Maryland / Department of Health and Mental Hygiene? For State Registrar 35495 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 3:30AM Johnson Isabelle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent Chestertown Nursing & Rehab. Center Chestertown 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 M F Hours Director Dec.11,1910 Maryland 170-20-7817 93 Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f show Examiner must be notified at 1 TYes 2 No Directo Chestertown Maryland Kent the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 Morgnec Road 21620 USA deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 "natural", or Specify: Specify. δ 3 ☐ Widowed 4 ☐ Divorced **Black** or then "nature Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Worker 4 Latex Factory it of Health and Mental Hygin If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Warner Lottey 2 Daniel K. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 N. Main Street, Hurlock, Maryland 21643 Lively / Niece Linda 20b. Place of Disposition (Name of cemetery, crematory or other place) Unk. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Pege Department o Important: If eny injury or once. Dover, Delaware Capitol Crematory 22. Name and Address of Facility
Bennie Smith Funeral Home
516 S. Main Street, Hurlock, Maryland 21643 21. Signature of Funeral Service Lie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOPULHONAM **Physician** /Medical Due to (or as a consequence of): **Examiner** Myocardent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed full flusion (or the acconsequence of): burial-tran Box 68760, attending physicien Physiclan/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate has autopsy 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1□Yes 2☑No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury within 24 hours after death.
To the Funerel Director: A completely filled in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-23889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar W.1).

32. Registrar's Signature

VN.

2004

VOLM C. ARRABAL

31. Date filed (Month, Day, Year)

223 High Street, CHEStintonn Wed 21420

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygier 0 0 4

35497

					Certificate	of Death	Re	g. No.			
			1. Decedent's Name (First, Middle, La	st)			2. Date of Death		3. Time of Death		
	Physici		DOCA E IONES	7			October	Day Year 19 2004	8:30 PM		
	/Medio		ROSA E. JONES 4e. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	4c. County of Death			
4	Examir	ier						1			
			Pineview Nursing		last hirthday) If Under 1 Y	Clinton Prince Ge					
	Funeral		5. Social Security Number 6. S	ITM OFFE		ear If Under 24 Hrs ays Hours Min	. (Month, Day,	Year) 9. Birth	place (State or Foreign intry)		
	Director		224-10-4/36	93	115.		January	22 Nort	h Carolina		
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or Location				10d. Inside City Limits		
	aryla	_	,		•				-		
	W P	윉	MD PRINCE (GEORGE'S Te	mple Hills				1√∑ Yes 2 No		
	1 28 E	Funeral Director	10e. Street and Number		10f. Zip Co	de	10	g. Citizen of What Cou	intry?		
	38 A	<u>.</u>	2813 Bellbrook S	Stroot	2074	0		U.S.A.			
	Jeath 2	ě	11. Marital Status	12. Was Decedent Ever in U.		O of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Amer	ican Indian,		
_	Ter Ter	֓֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֡	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🖾 No	If Yes, specify	Cuban, Mexican, Puer	to Rican, etc.)	Black, White	, etc.		
ಜ	should be filed within 72 hours efter death with the Maryland ind Mental Hyglene. It marked other then "netural; or items 23a or 28a-f show umatic event, the Medical Examinar must be mailled at	<u></u>	3 □XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀	No Specify:		Specify:	ack		
21215-0020	hou tt	귷	15. Decedent's Ed		16a Decedent's Usual O	ccupation	1	6b. Kind of Business/Ir			
5	n 72	Completed	(Specify only highest gra	ide completed)	16a. Decedent's Usual Or (Give kind of work de life. DO NOT use re	one during most of wo	orking	ob. Raile of Desiriossan	iddotty		
2	vithi P 6 6	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+)	Resident M			Private			
7	ygie ygie ner t	ပိ	12th		Resident II						
Maryland	d off	Be	17. Father's Name (First, Middle, Last)	1			me <i>(First, Middl</i> e, M es Ann Wac	_			
<u>=</u>	uld Men rke rtic	٦ 2	William Bailey			France	es Allii wad	16			
a	short and		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (St	reet and Number or R	ural Route Number,	City or Town, State, Zi	p Code)		
	alth a		Florine McCullou	gh/Daughter	2813 Bellbro	ook Street	Temple H	ills, Mary	land 20748		
ō,	tem tem		20a. Method of Disposition	20b. F	Place of Disposition (Name operatory or other	of (m/man)	Date 2	Oc. Location - City or T	own, State		
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural; or items 23a or 28a-1 show enty injury or other traumatic event, the Medical Examinet must be maified at once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐	Themoval from State			10-27-04	Brentwood	Maryland		
ŧ	rtme rtani		4 □ Donation 5 □ Other (Specif		. Lincoln Cer	-					
<u>a</u>	Depariment of the period of th	J. J	21. Signature of Funeral Service Licer	ISEE	22. Name and A	ddress of Facility	J. B. Jeni	kins Funera	al Home		
	= • O		6/13		7474 Lan	dover Road	l Landover	, Maryland	20785		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h. Do not enter the mode of	dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between		
-	Physician		SHOOK, OF HEART PRINCE TO SHOW	ene cause on each inte.					Onset and Death		
	/Medical		Immediate Cause (Final	Malignant	Non-Hodgkins	Lymphoma					
	Examiner		disease or condition resulting in death)	a		Бушрпоша		1			
		ē			or es a consequence of):			į			
	bed Jsit	Examiner	_	0	e Heart Failu	re		i			
	oentificate be executed inding physician and use as the buriel-transit	хаг	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	T as a consequence of).			1			
တ္ထိ	cian cian ourie	E .	cause. Enter Underlying Cause (Disease or injury	C				į			
68760,	ate l hysi the l	n/Medical	that initiated events resulting in death) Last	Due to (o	r as a consequence of):						
9	ng p ass	Ž.						į			
ŏ		an/	_	Q							
 m	deeth e ette ed for	泛	Part II. Other significent conditions o	ontributing to death but not res	ulting in the underlying cause	e given in Part I.	23b. Did tob	ecco use contribute t	o the ceuse of deeth?		
ö	res that the deeth signed by the ette I be deteched for	Physicia	E-1 C+ A1-1-				1 ☐ Yes	s 2√2 No 3 □ Pro	bably 4 Unknown		
. <u>.</u>	that hed l	by P	End Stage Alzhe	elmers Disease			, , , ,	-24.11			
g	uires sign ld be	p					24a. Was an	autopsy 24b. W	ere autopsy findings		
ŏ	w require been si should I	Completed					perform	ed? av	vailable prior to empletion of cause		
ĕ	law e 2 s	μ					ļ	of	deeth?		
	The ete l pag	Ö					1 ☐ Yes	3 2 No 1	☐Yes 2∏ No		
<u>a</u>	ien: intific ctor,	Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)			
Division of Vital Records, P.O.	Attending Physicien: The law requires that the death or death. ector: Atter this certificate hes been signed by the etter by the tuneral director, page 2 should be deteched for the tuneral director, page 2.	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DOA	Other: 4 Nursing I	Home 5□ Residen	nce 6 □Other (Speci	fy)		
0	a Ph		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury	Injury at Work?	28d. Describe how	v injury occurred			
<u>o</u>	Aft.	ij.	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation			1 Yes 2 No					
<u> S</u>	dea ctor ctor by th	Certification:	3 ☐ Suicide 6 ☐ Could not be	289. Place of injury - At he	ome, farm, street, factory, off	ice	28f. Location (Stre	eet and Number or Rur	al Route Number,		
2	or / efter Dire	eri	4 ☐ Homicide	building, etc. (Specify	y)		City or Town,	State)			
	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funerel Director: Affer this certificate hes completely filled in by the funeral director, page 2		29a, Certifier 1 To Certifying Ph	ysician: To the best of my kno	wiedne death cooured at th	e time data and stand	and due to the co-	see(s) and manner	stated		
	Hos Fun fely	edical		niner: On the basis of examina							
	hin the	Mec		and manner stated.	200 1 1	cense number	20.	d. Date signed (Month,	Day Voar)		
_	₽ ₹ 6 8		29b. Signature and title of certifier	Wat .		51520		а. Date signed (молгл, 10 - 20 - 0			
			PIOYVOON	(1)	0	21270		10-20-0	7		
Λ	(11)		30. Name and eddress of person who	completed cause of death (Item	n 23a) (Type, Print)						
K	イヤ		Bahram Pishdad M.	D. 9801 Georg	ia Avenue # 3	41 Silver	Spring. M	arvland 20	902		
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signa							
			AAT 9 # 200		- 4						

DHMH 16 Rev 6/95

			1 - State Unpend Item 2 1. Decedent's Name (First, Middle, Last		ne G837 _{Ce}	artment of H 1-16-04 t rtificate of t	ealth and M Beath	Rec 2. Date of Death	5	35498	
	Physici /Medi			lnora	Jones			Month	30, 2004	0735 P M	
	Examir		4a. Facility Name (If not institution, give				Location of Death		4c. County of Death		
9	F		13614 Hollow Log I 5. Social Security Number 6. Se		n yrs. last birthday)	Upper Ma	If Under 24 Hrs.	8. Date of Birth	Prince Ge		
0	Funeral Director		201-22-3181	□M 25kF 77	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) January	14 Virg	place (State or Foreign ntry) inia	
-	land ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits	
	death with the Maryland ms 23e or 28e-f show f must be notified at	tor	DC		Washingt	on,DC				1X Yes 2 □ No	
	ith the	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?	
	s 23e	eral	3100 Connecticu	t Ave N. W. 12. Was Decedent Eve		20008	annia Orinina (Car	oft. Voc or No	U.S.A.	and ladies	
920	after or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2€ No	spanic Origin? (Spen, Mexican, Puerto I	Rican, etc.)	14. Race - Ameri Black, White, Specify: B1		
5-0	72 hours "naturel", dicel Exc	eted	15. Decedent's Edu (Specify only highest grad	cation le completed)	/Give	dent's Usual Occupa kind of work done of	lurina most of workii	ng 16	6b. Kind of Business/In	ndustry	
Maryland 21215-0036	be filed within 72 hr tal Hygiene d other than "natu event, Tie Mad Cal	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Teac	DO NOT use retired,)		Government		
ام 2	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, I.e.M.	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma			
ylar	should be faind Mental 8 marked of	ToE	Holland Fisher				Mildred				
Mar	d 2 sh th and 7 Is m treum		19a. Informant's Name/Relationship (T) Massie Jones/Son	rpe, Print)					City or Town, State, Zip	/.11//4	
	s 1 and f Heal item 2 other		20a. Method of Disposition		20b. Place of Dispo		D		Marlboro, M		
altimore,	Pages nent of i		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Church (,	11/5	/04	Evinton Car	mpbell,VA	
Holland Fisher Holland Fisher 19a. Informant's Name/Relationship (Type, Print) Massie Jones/Son 13614 Hollow Log Drive Up 20a. Method of Disposition 1 28 Burial 2 Cremation 3 Removal from State 1 2 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. 7474 Landover Road Lan									ns Funeral , Maryland		
			23a. Part1. Enter the disease or complishock, or heart failure. List only o	ications that caused the ne cause on each line.						Approximate Interval Between	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metastatio		Cancer				Onset and Death	
	Examiner			Due to (or as a co	onsequence of):						
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):						
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
68760,	te be executed ysician and e burial-transit	cal E		d							
_	ntificate ng phys s as the	Medical	IF FEMALE:								
P.O. Box	The law requires that the death certificate be executed ate been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year	
	ires that signed b	by	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to the		
Core	w require been si should b	letec						24a. Was an			
Vital Records,	The favile hes	Completed						autopsy performe	d? prior to condeath? No 1 ☐ Yes	psy findings available mpletion of cause of	
/ital		BeC	25. Was case referred to medical examiner?				26. Place of Death		12 103	20140	
of V	Physicien: r this certifica ral director, I	은	1 No 2 No 2 No 27. Manner of Death	lospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien		4 Nursing Hom		e 6 Opther (Specify	At scene	
O	Afte Fune	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury	Work'	at ? es 2 □ No	8d. Describe how	injury occurred		
Division	of or Attendia after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,	
	To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) 1□ Certifying Phy 2☒ Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated.	amination and/or inv	occurred at the fime restigation, in my opi	e, date and place, a nion, death occurre	nd due to the caus d at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License		29d.	. Date signed (Month,	Day, Year)	
7			Panel 5	rithall, or	1)	O.C.M.	Е.	Oc	ctober 31,	2004	
K	/		30. Name and address of person who co	mpleted cause of death			street, Ba	ltimore,	Maryland	21201	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 4 2004	2. Registrar's	Signature	U					

4 - OS	6874	300		State of Maryland / Department				251.00
00			1 - For State Registrar	Ce	rtificate of Death	Reg.		35499
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Robert Ellis	Jones JR.		2. Date of Death Month October		3. Time of Death $1525 p^M$
	Examin	er	4a. Facility Name (If not institution, give s Shock Trauma	treet and number)	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral Director		210-00-3232	7. Age (In yrs. last birthday) The state of the state o	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Oct. 13	ear) Coun	ace (State or Foreign try) VA
	deeth with the Maryland me 23a or 28a-f ehow r must be notified at	or	Usual Residence of Decedent 10a. State 10b. County MD Washing	10c. City, Town or Lo	ocation sville		10	Od. Inside City Limits
	ith the A or 28a-t	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?
	e 23a		5835 Red Hill		21756	nacify Vas or No-	USA 14. Race · America	an Indian
320	n /2 hours aller deem with the marylan "natural", or iteme 23a or 28a-f ehow -alcal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	Was Decedent of Hispanic Origin? (Slif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	o Rican, etc.)	Black, White,	
212-0030		Completed	15. Decedent's Educ (Specify only highest grade	a completed) (Give	edent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	king 16	b. Kind of Business/Inc	lustry
7 7	d within giene. er than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	ales manager		paint co) •
n n	ld be filed ental Hygic ked other ic event, I	Be	17. Father's Name (First, Middle, Last) Robert E. Jone	ac CD		ne (First, Middle, Ma		
maryland	shou mar mat	To	19a. Informant's Name/Relationship (Ty		ing Address (Street and Number or Ru	ny J. Do		Code)
	27 is		Linda Jones (Wi	.fe) 583	5 Red Hill Rd.	, Keedys	ville, MI	21756
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial ★□ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place) urg Crematory 1		c. Location - City or To Smithsbur	
Saltı	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	30 2	Name and Address of Facility Donald B. Thom	son Fun	eral Home	
	40 F & 0		23a, Parit: Enfer the disease, or compli	cations that caused the death. Do not en	31 E. Main St.	<u>, Middle</u>	town, MD	21769 Approximate
Ì	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	wits			Interval Between Onset and Death
		Iner	Sequentially list conditions. Tary leading to immunistic cause. Enter Underlying Cause, (Disease or Injury)	Due to for as a consequence of:				
,09/	e be executed ysicien and e burial-transit	cal Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
Box 68	leath certificate attending phys	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [23d. Date of delive	ry
ю. О	the death y the atte	ysicia	in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		Month	Day Year
<u>a</u>	uires that the de signed by the a ld be detached f	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobad 1 ☐ Yes	cco use contribute to the	e cause of death? ably 4 Dunknown
Records,	The law requires that the death certificate to has been signed by the attending phy cage 2 should be detached for use as the	Completed				24a. Was an autopsy performe	prior to cor death?	osy findings available npletion of cause of
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical		26. Place of Dea	th (Check only one)	No 1 Yes	2 L No
<u>_</u>	Physici this cer al direc	To B	TEXTES 2 NO	Hospital: 1 ☐ Inpatient 2X ER/Outpatien			e 6 □Other (Specify	
Division of Vital	nding Pl ath. r: After the e funera		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) (O-22-04) 28b. Time of Injury		DRIUM OF	injury occurred	TUES PULCO
Divis	al or Atte s after de il Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S RT27 at NEW		Route Number, W FREDERUCKO
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical (sician: To the best of my knowledge, deat ner: On the basis of examination and/or ir and manner stated.				
	To th within To th comp	Me	29b. Signature and title of certifier	re Will	29c. License number OCME		Date signed (Month, Cotober 24,	
	10		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	111 Penn Stree	et, Baltim	ore, Maryla	and 21201
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	6 1			

State Registrar

				For State Registrar	State of M	Naryland / De	epartme Certifica				giene 0 (200)4	35500
		Physic	ian	Decedent's Name (First, Middle, L. WILLIAM	RICHARD		KREH			2. Date of Dea	ith Day	Year	3. Time of Death
		/Medi Examir		4a. Facility Name (If not institution, gi				, Town, o	or Location of Deat	October	4c. County		4:15 a ^M
				Casey House	Co., 7.0	Anna (In sum In an hintha		ckvi er i Year	11e	1 0 D-1- (Dist	Mon	tgom	ery place (State or Foreign
		Funeral Director		5. Social Security Number 6. 319 20 9815	Sex 7. A 1 M 2 □ F 7. A	Age (In yrs. last birtho 76 Yrs	Months		Hours Min.		, Year) , 1928	000	place (State or Foreign ntry) inois
	8	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
		Maryl a-f sho	tor	Maryland Montgom	e ry	Silver	Sprin	ıg					1 Yes X No
		with the	Funeral Director	10e. Street and Number	-1		10f. Z	ip Code	000		10g. Citizen of V		ntry?
		death v	eral	13228 Hathaway D	12. Was Deceden	nt Ever in U.S.	13. Was Dece		906 Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race		can Indian,
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show many july go other traumatic event, Ire M. sical Ex. other must be nutilled at once.	by Fur	1 Never Married 2 Married	Armed Forces 1 X Yes 2 If Yes, Give	JNO MMTT	ir Yes, spe			to Hican, etc.)	Specify	k, White, · Wi	etc. nite
	00-	2 hour atural	ted b	3 X Widowed 4 □ Divorced 15. Decedent's 8	Year or Dates	16a. De	ecedent's Usi	ual Occup	pation		16b. Kind of Bu	siness/In	ndustry
	121	vithin 7 ne. han "n	Completed	(Specify only highest ga	College (1-4o	r 5+)			during most of wo d)	rking	N		
	d 2	filed v Hygie other t ent, In	Be Co	17. Father's Name (First, Middle, Las	t)	J	ournal	ıst	18. Mother's Na	me (First, Middle,	Navy 1 Maiden Sumam		
	ylan	Mental Mental arked	To B		mes	Kreh			Haze1	Vant			
	Maryland 21215-0036	d 2 shoth and the and the shoth the		19a. Informant's Name/Relationship	-					ural Route Numbe	1000		
	ore,	ss 1 an of Heal item 2		Donna Greenleaf 20a. Method of Disposition		20b. Place of D	isposition (Na crematory or	me of		rson, Mai Date	20c. Location -		
	Baltimore,	tment c		12CBurial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spec	(4)	Parklaw	n Mem	Park	10/	22/2004 1			
	Bal	permit Depar impor any in		21. Signature of Funeral Service Lice	en la					nes Rinal e Ave Sil			Home MD 20904
				23a. Part1. Enter the disease, or cor shock, or leart failure. List only	nplications that cause one cause on each	ed the death. Do not							Approximate Interval Between
		Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		ed Lung Ca		ith !	Brain Me	taistases	3		Onset and Death
		Examiner		1	Due to (or a	is a consequence of):							
	1	ait sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		is a consequence of):							
	,	execution and ial-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	is a consequence of):							
e in	8760	cate be executed physician and the burial-transit	dicai		d					×			
T		eath certific attending p	/Mec	IF FEMALE:	23c. If yes, outcom	ne of pregnancy					23d. Date	of deliv	erv
	Box	that the death certifi ed by the attending I detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)		at time of death	3 □Ectopic p 5 □ Other (s		y		Mor		Day Year
5	P.0	es that the de igned by the be detached	Phys	9 ☐ Unknown Part II. Other significant conditions			a underhina	cause and	on in Part I	23e Did to	hacco use contr	bute to t	he cause of death?
VIIIan	Records,	quires tha n signed uld be det	d by				o dildonying						pably 4x Unknown
>	ecol	The law requires ite has been sign page 2 should be	Completed							24a. Was a		Vere auto	ppsy findings available impletion of cause of
	_	aician: The law certificete has t irector, page 2 s								perform	ned? d	eath?	
	Vita	raician s certifi lirector	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 □ Innat	tient 2 ER/Outpa	itient 3 🗆 D	OA Oth		ath <i>(Check only on</i> Home 5□ Reside		r /Specif	
T.	Division of Vital	ng Phy fter this neral c	on: T	27. Manner of Death 13 Natural 5 ☐ Pending	28a. Date of In (Month, D			28c. Injur Wor	y at rk?	28d. Describe ho			77
No	isio	death ctor: A	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	oe Zee Blees of le	njury - At home, farm	M street facto		Yes 2 □ No	28f. Location (St	reet and Numbe	r or Rura	al Route Number
5	Div	s after s after at Dire	Certi	4 ☐ Homicide determined	building, e	etc. (Specify)		,,		City or Town	n, State)		
		To the Hospital or Attending Physician: The within 24 hours after death To the Fullers Intercor: After this certificate his completely filled in by the fulleral director, page	edical (29a. Certifier Certifying P	hysician: To the bes miner: On the basis and manners	st of my knowledge, d of examination and/o	eath occurred r investigation	d at the tir n, in my o	me, date and place opinion, death occu	a, and due to the curred at the time, d	ause(s) and mar ate and place, a	ner as s	tated. the cause(s)
		To the within 2 To the comple	Med	29b. Signature and titte of certifier	and manners	otateu.	29	c. Licens	se number	2	9d. Date signed	(Month,	Day, Year)
		(0		Mah	THE			DI	1121	8	10/19	100	7
		4		30. Name and address of person who Charles Harrison				l Ros	ad Rooks-	11e Ma-	wlond	208	50
		⇒ Sta	ate	31. Date filed (Month, Day, Year)	32, Regis	strar's Signature				TIE, MAI	утапа	208	30
	E	Regist	rar	OCT 25 20	U4 /20	wa B	200	uks	1				